98th Congress } SENATE { Rept. 98-360
*2d Session* } { Vol. 1

# DEVELOPMENTS IN AGING: 1983
## VOLUME 1

A REPORT

OF THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

PURSUANT TO

S. RES. 76, MARCH 2, 1983

Resolution Authorizing a Study of the Problems
of the Aged and Aging

February 29 (legislative day, February 27), 1984.—Ordered to be printed

U.S. GOVERNMENT PRINTING OFFICE
30-629 O WASHINGTON : 1984

S143-1

## SPECIAL COMMITTEE ON AGING

JOHN HEINZ, Pennsylvania, *Chairman*

PETE V. DOMENICI, New Mexico
CHARLES H. PERCY, Illinois
NANCY LANDON KASSEBAUM, Kansas
WILLIAM S. COHEN, Maine
LARRY PRESSLER, South Dakota
CHARLES E. GRASSLEY, Iowa
PETE WILSON, California
JOHN W. WARNER, Virginia
DANIEL J. EVANS, Washington
JOHN GLENN, Ohio
LAWTON CHILES, Florida
JOHN MELCHER, Montana
DAVID PRYOR, Arkansas
BILL BRADLEY, New Jersey
QUENTIN N. BURDICK, North Dakota
CHRISTOPHER J. DODD, Connecticut
J. BENNETT JOHNSTON, Louisiana
JEFF BINGAMAN, New Mexico

JOHN C. ROTHER, *Staff Director and Chief Counsel*
DIANE LIFSEY, *Minority Staff Director*
ROBIN L. KROPF, *Chief Clerk*

# LETTER OF TRANSMITTAL

---

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
*Washington, D.C., February 29, 1984.*

Hon. GEORGE BUSH,
*President, U.S. Senate,*
*Washington, D.C.*

DEAR MR. PRESIDENT: Under authority of Senate Resolution 76, agreed to March 2, 1983, I am submitting to you the annual report of the Senate Special Committee on Aging, Developments in Aging: 1983, volume 1.

Senate Resolution 4, the Committee Systems Reorganization Amendments of 1977, authorizes the Special Committee on Aging "to conduct a continuing study of any and all matters pertaining to problems and opportunities of older people, including, but not limited to, problems and opportunities of maintaining health, of assuring adequate income, of finding employment, of engaging in productive and rewarding activity, of securing proper housing and, when necessary, of obtaining care and assistance." Senate Resolution 4 also requires that the results of these studies and recommendations be reported to the Senate annually.

This report describes actions during 1983 by the Congress, the administration, and the Senate Special Committee on Aging which are significant to our Nation's older citizens. It also summarizes and analyzes the Federal policies and programs that are of the most continuing importance for older persons, their families, and for those who hope to become older Americans in the future.

On behalf of the members of the committee and its staff, I am pleased to transmit this report to you.

Sincerely,

JOHN HEINZ, *Chairman.*

# SENATE RESOLUTION 76 (SECTION 19), 98TH CONGRESS, 1ST SESSION [1]

Sec. 19. (a) In carrying out the duties and functions imposed by section 104 of S. Res. 4, Ninety-fifth Congress, agreed to February 4, 1977, and in exercising the authority conferred on it by such section, the Special Committee on Aging is authorized from March 1, 1983, through February 29, 1984, in its discretion (1) to make expenditures from the contingent fund of the Senate, (2) to employ personnel, and (3) with the prior consent of the Government department or agency concerned and the Committee on Rules and Administration, to use on a reimbursable basis the services of personnel of any such department or agency.

(b) The expenses of the special committee under this section shall not exceed $1,036,131, of which amount (1) not to exceed $35,000 may be expended for the procurement of the services of individual consultants, or organizations thereof (as authorized by section 202(i) of the Legislative Reorganization Act of 1946, as amended), and (2) not to exceed $1,000 may be expended for the training of the professional staff of such committee (under procedures specified by section 202(j) of such Act).

---

[1] Agreed to March 2, 1983.

# PREFACE

The United States stands today at a significant demographic turning point—for the first time in our history, there are as many Americans aged 65 and over as teenagers. There is much more going on than simply the growing numbers of older Americans. What we are witnessing is the growing assumption by a majority in our society that they can expect 10 to 20 years of life after work, in relatively good health and with adequate and secure retirement income. The most severe problems associated with growing old—chronic illness, poverty, and social isolation—persist, but for many they are being delayed until beyond ages 75 or 85. The widespread emergence of this new period of healthy, financially secure retirement promises great opportunities for both individuals and for our society, if only we can learn to reap the full social, economic, and personal dividends of this new time of life. The great increases in the number of very old persons, however, poses tremendous challenges to our systems of health care, retirement financing, housing, and social and community services.

The Congress took a major step toward meeting the challenges facing an aging society when it acted during 1983 to restore financial solvency to the social security retirement program. It also took an important step toward reform of the medicare program by converting from cost-based reimbursement to a system of set prices for hospital admissions, according to diagnosis. The long-term implications of both steps are likely to be profound. Despite these major accomplishments, serious problems in both retirement income adequacy and health care financing remain unresolved.

Although 1983 will be remembered as the year that the social security retirement program was financially stabilized, it marked only the beginning of the effort to similarly stabilize health care financing. The two major categories of Federal programs benefiting older Americans—retirement benefits and health insurance programs—today cost over $300 billion, or 9.8 percent of our total gross national product. Future projections based on current policies show very different patterns of financial growth for each. Federally financed retirement benefits are expected to decline from 7.1 percent of GNP in 1982 to a low of 5.6 percent of GNP in 2005, before rising again to a second peak of 7.1 percent in 2030. Whatever else that can be said about the causes of the Federal deficit, retirement financing over the long term will play a neutral role. Not only is the OASDI trust fund likely to remain solvent over that period, it will never take a substantially greater share of our economic resources to finance at any time in the future than it does today.

Health financing, however, presents a very different story. The rate of increase in health expenditures today constitutes perhaps the single most destabilizing element in the Federal budget on the domestic side. Federal health insurance programs are projected at current rates of increase to rise from 2.7 percent of GNP today to 7.5 percent by 2040—in effect, adding almost 5 points to the structural deficit problem.

Projections of this magnitude make clear that the principal domestic challenge facing the Congress today is that of controlling rising health care costs. Hospital costs have been rising at a rate almost three times as fast as inflation for the past 10 years, due mostly to increases in the intensity of medical services (the number of tests and procedures) provided to each person and to increases in the charges for these services that have far exceeded increases in cost generally. As a result, medicare faces projected insolvency as early as 1990 and cumulative deficits in the range of $90 to $250 billion by 1995. It seems clear that only major and comprehensive reforms will be adequate to successfully cope with problems of that size.

While these issues are analyzed and debated within the Congress as budgetary matters, they also have significance for individuals, families, and the economy. Out-of-pocket expenditures for health care today average over $1,500 for Americans 65 and over, substantially more for those older Americans who must actually use health care services during the year. In 1983, these out-of-pocket health costs averaged over 20 percent of the median per capita income for persons 65 and over. These out-of-pocket costs have been rising at a rate 2 to 3 times that of other prices—a trend that constitutes the most serious and direct threat to the future economic and health security of older Americans.

Our health problems are not limited to medicare financing alone. Most families faced with the responsibility of caring for an aging relative with a chronic illness or functional limitation find little or no help in our current public programs, and very limited services available in the private sector. The situation of a family with a member suffering from Alzheimer's disease illustrates the burdens that no public or private insurance coverage adequately meets. With total national health care expenditures now equal to 11 percent of GNP, it seems that sufficient resources are already available to meet a wider range of health care needs if more coordinated and efficient delivery systems could be established. A variety of legislative proposals to do that are now under consideration in the Congress.

Better health care and better public health measures have improved average life expectancy dramatically—by over 25 years since the turn of the century. But increasing longevity does not always translate into improvements in the quality of life. There is disturbing evidence that much of the recent gains in an extended lifespan may have been accompanied by a corresponding extension in the period of poor health and functional disability prior to death. This evidence implies an even greater need for a strengthened network of long-term care services than do projected increases in longevity alone.

Although medical technology has contributed to our ability to cure sickness and to restore disability, it has also extended our ability to keep dying persons alive for longer and longer periods.

The cost of this aspect of health care is illustrated by the fact that 30 percent of medicare expenditures pay for care in the last year of life. These facts raise difficult ethical and policy issues. One response has been a renewed interest in less intensive forms of health care options. Congress, in response both to cost concerns and to evidence that many patients prefer a more personally supportive and less technologically intensive environment, enacted a hospice benefit under medicare in 1982. The increasing support for home health care programs also reflects congressional and popular interest in making more appropriate noninstitutional alternatives available.

The economic well-being of older persons continues to be a serious concern. Despite an official poverty rate of 14.6 percent in 1982 for Americans 65 and over, which is roughly the same proportion in poverty as for younger persons, there has been little improvement in this figure for almost 10 years. Yet the aggregate figures hide two important facts. First, there are relatively more older Americans living just above the poverty threshold, with only social security, medicare, and other assistance programs keeping them from falling beneath it. Median per capita income for Americans 65 and over was only $6,600 in 1982. Second, there persist clear groups of older persons who bear a very high risk of being poor: widows, minorities, those who are sick, and those who have lived into their eighties. For these groups, poverty remains at crisis levels.

The provision of a full cost-of-living adjustment (COLA) for social security benefits is directly related to poverty among the aged and very old. As a person becomes very old, the protection against inflation that the full COLA provides becomes increasingly vital. Persons over 85 are likely to have disproportionately high expenditures for health care, supportive services, and energy costs, yet by that age they are much more likely than younger individuals to have exhausted savings or other resources necessary to meet these higher expenses. COLA limitations would reduce the value of retirement benefits the longer they were received. New retirees would not be affected, but older beneficiaries—those most reliant on benefits to support their basic needs—would have the real value of those benefits reduced every year.

The persistence of high poverty rates in the face of the immense resources that we devote to programs supporting older Americans seems to be a paradox. Unmet needs remain even as public resources near exhaustion. This paradox, combined with the increasing economic and health diversity of the older population, is leading many policymakers to reexamine the use of age criteria alone as the basis for public benefits. There is a growing interest in using other criteria in addition to age that more directly assess need. An example of the congressional openness to this thought is its decision to make half of social security benefits taxable, but only for beneficiaries with substantial additional sources of income.

In the other areas of Federal programs serving older persons, there is increasing concern that in developing separate programs for housing, income support, health and social services, all directed to the same population in need, we may have permitted serious inconsistencies in policy, coverage gaps, and inequities in benefits to arise. There seems to be a clear need to reassess these programs from a more integrated and comprehensive perspective, to reflect how well they are meeting human needs that are increasingly likely to involve more than one category of program in the community.

The coming 2 years offer the Congress the opportunity to review and reassess our major aging programs on the anniversaries of their enactment. The social security retirement program will be 50 years old in 1985; medicare, medicaid, and the Older Americans Act, 20 years old the same year; ERISA and the SSI program 10 years old in 1984.

In light of these and many other public policy issues of concern to all Americans, the Senate Special Committee on Aging has engaged in a productive year. We continue to expand our efforts to inform the public through committee prints and newsletters, and our hearings have focused on the most pressing issues before the Congress. In many instances, members of the committee were able to successfully propose legislative initiatives designed to better serve older Americans as a result of the committee's work.

The report that follows discusses these developments in 1983. It surveys only Federal policies and programs. Equally significant developments that are occurring at the State and local levels, in the private sector, in our universities, in cultural attitudes, or in our family relationships are not covered. It is the interaction of these elements that will shape the opportunities of future generations of older Americans.

We are proud to acknowledge the dedicated work of the authors of this report, the staff of the Senate Special Committee on Aging. This report is a synthesis of the working knowledge they bring to the service of the committee.

In sum, while we are inevitably maturing as a population, the process will not be a smooth or gradual one. Instead, the postwar baby boom generation now in young adulthood will bring very sudden and dramatic transformations to each decade as it matures. When this generation nears retirement age, beginning around the year 2010, the dislocations could be severe if we do not plan for this event well in advance. In effect, we have only 30 years to prepare for major, yet foreseeable, changes in our society.

As we near the close of the 20th century, we can see with ever greater clarity the challenges that will be before us in the 21st. One of the clearest is the need to recast some of our most basic policies in work and retirement, health care and social services, in both public and private sectors, to adapt to an older population. This challenge is hardly a negative one—an older society presents many opportunities for greater personal freedom and greater economic productivity—but it can easily become negative if we fail to anticipate the changes that will occur or plan now to adapt to them. In the end, an older and more stable age-structure can lead to a more mature society, in the full sense of that term. It is this vision of the future that can guide us in facing the challenges made possible by the promise of longer life.

JOHN HEINZ,
*Chairman.*
JOHN GLENN,
*Ranking Minority Member.*

# CONTENTS

Page
Letter of transmittal .......... III
Senate Resolution 76 (section 19), 98th Congress, 1st session .......... V
Preface .......... VII
Chapter 1. America in transition: An aging society .......... 1
Chapter 2. Economic performance and the Federal budget .......... 80

PART I. RETIREMENT INCOME .......... 95

Chapter 3. Social security .......... 112
Chapter 4. Employee pensions .......... 153
Chapter 5. Assets: Savings and capital accumulation plans .......... 236
Chapter 6. Employment .......... 268
Chapter 7. Social security disability .......... 294

PART II. LOW-INCOME ASSISTANCE PROGRAMS .......... 323

Chapter 8. Supplemental security income (SSI) .......... 332
Chapter 9. Food stamps .......... 347

PART III. HEALTH .......... 353

Chapter 10. Health care expenditures .......... 361
Chapter 11. Federal programs providing health coverage for the elderly .......... 378
Chapter 12. Federal health legislation and Aging Committee oversight in the 98th Congress .......... 393
Chapter 13. Long-term care .......... 418

PART IV. HOUSING .......... 447

Chapter 14. Federal housing programs .......... 453
Chapter 15. Private housing options for older Americans .......... 467
Chapter 16. Energy assistance and weatherization .......... 477

PART V. SOCIAL SERVICES .......... 493

Chapter 17. Older Americans Act .......... 497
Chapter 18. ACTION: Volunteer programs for older Americans .......... 524
Chapter 19. Legal services .......... 532
Chapter 20. Social and community services .......... 547

PART VI. PERSONAL SAFETY OF THE ELDERLY: CRIME AND ACCIDENTAL FIRES .......... 573

Chapter 21. Crime and the elderly .......... 574
Chapter 22. Home fire safety .......... 581
Chapter 23. Consumer frauds and deceptions .......... 585

SUPPLEMENTAL MATERIAL

Supplement 1. 1983 hearings held before the Senate Special Committee on Aging .......... 593
Supplement 2. Committee prints and reports printed by the Special Committee on Aging in 1983 .......... 607
Supplement 3. Staff of the Senate Special Committee on Aging .......... 608
Supplement 4. Publications list .......... 609

98th Congress
*2d Session*

SENATE

Rept. 98-360
Vol. 1

---

# DEVELOPMENTS IN AGING: 1983

## VOLUME 1

---

February 29 (legislative day February 27), 1984.—Ordered to be printed

---

Mr. Heinz, from the Special Committee on Aging,
submitted the following

# REPORT

[Pursuant to S. Res. 76, 98th Cong.]

---

## Chapter 1

## AMERICA IN TRANSITION: AN AGING SOCIETY*

America is growing older. One of the most significant demographic facts affecting America's present and future course is the aging of its population. The proportion and number of persons 65 years and older has grown and will continue to grow more rapidly than other age groups.

A quick overview of this surge in the size of the older population highlights such facts as:

*Growth.*—Elderly persons comprise the fastest growing segment of the population:

—The older population grew twice as fast as the rest of the population in the last two decades.

---

* "America in Transition" will be printed annually by the U.S. Senate Special Committee on Aging. This chapter was revised and unpdated for the 1983 publication by Elizabeth Vierck and John Rother, staff, U.S. Senate Special Committee on Aging. The Congressional Research Service provided invaluable support. The first edition was coauthored by John Rother, Cynthia Taeuber (U.S. Census Bureau), and Elizabeth Vierck, and was published by the U.S. Senate Special Committee on Aging in "Developments in Aging, 1982," and by the U.S. Bureau of the Census, Series P-23, No. 128.

—The 85-plus population grew especially rapidly, up 165 percent from 1960 to 1982. This "very old" population is expected to increase fivefold by the middle of the next century.

—Not only are the numbers of elderly persons increasing, but the proportion of elderly in the population as a whole is also expanding. Over 25 percent of the population will be 55-plus by the year 2010.

—Life expectancy improved dramatically over the last century. The average person born today can expect to live 25 years longer than if he was born at the beginning of the century.

—Women live longer than men. In 1982, the life expectancy of females (78.2 years) was almost 8 years longer than the life expectancy of males (70.8 years).

—Elderly mortality (or death) rates, a statistical measure of the frequency of deaths in population groups, fell considerably over the last 40 years, especially for women.

—The ratio of elderly persons to nonelderly has increased from 1 to 25 at the beginning of the century to 1 out of 9 in 1980. This ratio is expected to be at least 1 to 5 in 1990 and 1 to 3 in 2025.

—Today, the 65-plus population is about equal to the teenage population, those aged 13 to 19 years. By the year 2000, there will be an estimated four 65-plus persons for every three teenagers and, by 2025, elderly persons will outnumber teenagers by more than 2 to 1.

*Income.*—The economic situation of many elderly persons has improved, yet large numbers remain poor:

—The median income of elderly persons had a higher percentage increase over the last two decades than the median income of the younger adult population.

—Despite this improvement, about one of every seven Americans over the age of 65 lives in poverty. And, close to one-fourth of all elderly Americans are "near poor" (below 125 percent of the official U.S. poverty level).

—Elderly women are almost 70 percent more likely than elderly men to be poor. Fifty percent of elderly widowed black women live in poverty.

—A recent census study analyzing the impact of taxes on income demonstrate that, due to favorable tax treatment and social security incomes that keep up with inflation, the median after-tax income of elderly households is higher than that of most younger age groups. However, analysis of the after-tax income distribution of elderly households demonstrates that, even after taxes, the majority of elderly persons have incomes at the low end of the income scale, in sharp contrast to younger age groups whose incomes are clustered in the middle range of the income scale.

*Health.*—The majority of elderly are healthy, even though they may have a chronic condition:

—About 8 in 10 persons 65 and over now describe their health compared with others of their own age as "good" or "excellent."

—While one-third of the 85-plus population is in good health, one-third are limited to some degree—but not severely—and another third need assistance in living due to health problems.

The greatest need for health and related care is in this age group.

*Women and men.*—Elderly women outnumber elderly men:

—The ratio of elderly women to men is now 3 to 2.

—Elderly men are most likely to be married, while elderly women are most likely to be widowed.

—The number of elderly women living alone has doubled in the last 15 years. Most older women live alone, while most older men live in family settings.

*Location.*—The geographic distribution of older populations is shifting to rural, small town, and retirement areas:

—During the last decade, the number of elderly persons living in central cities has declined, while the number living in the suburbs and small towns has increased.

—Even though this shift has taken place, the majority of older Americans still live in metropolitan areas.

—Older persons change residences at about one-half the rate of the younger population.

—Over 70 percent of all elderly persons live in owner-occupied households, and 80 percent of these homes are mortgage free.

*Work and retirement.*—The majority of elderly persons do not work:

—Today, after age 65, only about 1 in 5 elderly men are employed as compared to 1 in 2 in 1950.

—Only about 1 in 5 of those over 65 who work now do so on a part-time basis, as compared to 1 in 3 20 years ago.

—The proportion of a man's life spent in retirement has increased from 3 percent at the turn of the century to 20 percent in 1980.

*Education.*—The educational "gap" between older and younger persons has narrowed significantly in the last decade and is expected to close in the next decade:

—The median number of school years completed is now 12.1 years for the "new" elderly, 65 to 69 years of age, as compared to 9 years for the 75-plus age group. The median for the 25-plus age group is 12.6 years of school.

*Voting.*—Older persons vote in large numbers:

—In 1982, the 55 to 74 year old age group had the highest voter participation rate, 65 percent, and the 18 to 20 year old age group the lowest, 20 percent.

These and the trends outlined in the following pages delineate the impact the aging of the population is having and will continue to have on American society.

"Aging" is a general term which can be defined as a physiological, behavioral, sociological, or chronological phenomenon. This chapter will use the chronological concept to look at the population 55 years and over on the assumption that the other aspects of aging tend to follow chronological age for large populations. When possible, the statistics will be distinguished for the "older" population (age 55 to 64), the "elderly" (age 65 to 74), the "aged" (75 years to 84), and the "very old" (85 years and over).

## A. THIS CENTURY HAS SEEN TREMENDOUS GROWTH IN THE OLDER POPULATION

The older population has been increasing at a far more rapid rate than the rest of the population for most of this century. For instance, in the last two decades, the 65-plus population increased at a rate of 24 percent, while the under-65 population increased only 6 percent.

At the beginning of the century, about 7.1 million persons, less than 10 percent of the total population, were age 55 and over. In 1982, 48.9 million persons, or over 20 percent of the American population was 55 years old or over. Of the total population, about 9.5 percent (22.1 million) were 55 to 64 years old; 7 percent (16.1 million) were 65 to 74 years old; 3.6 percent (8.2 million) were 75 to 84 years old; and 1.1 percent (2.5 million) were 85 years old and over. About 15,000 persons were aged 100 and over, with over 66 percent of that group being white females.

### 1. The Aging of the Baby Boom Will Increase

### THE PROPORTION OF OLD TO YOUNG IN THE POPULATION

The total U.S. population is projected to increase by one-third from its present size between 1982 and 2050, while the 55-plus population is expected to more than double (table 1, chart 1).[1] Through the year 2000, the proportion of the population age 55 and over is expected to remain stable, at just over 20 percent of the total population. By 2010, because of the maturation of the baby boom, the proportion of older to younger will rise dramatically—25 percent of the total U.S. population (74.1 million) is projected to be at least 55 years old. Twenty-two percent of Americans are expected to be 65 and over (39.3 million), and the number of persons aged 85 and over will more than double to 6.8 million or 2.4 percent of the total population.

By the year 2030, it is likely that 21 percent of all Americans will be 65 or older (64.3 million), which will represent a 64-percent increase in a 20-year span. At that same time, almost 3 percent of the population will be 85 or older (8.8 million). Finally, by 2050, 34 percent of the population (104.3 million) is expected to be at least age 55.[2]

---

[1] U.S. Dept. of Commerce. Bureau of the Census. Projections of the Population of the United States 1982 to 2050 (Advance Report), Current Population Reports. Series P-25, No. 922, October 1982. The projections used here are the "middle" series which assumes that fertility rates will remain steady, life expectancy will rise slowly, and net immigration will remain at 450,000 per year. The accuracy of the projections of the number of older Americans depends primarily on the accuracy of the mortality assumption; the accuracy of the percentage depends additionally on future birth rates, and thus we have less confidence in the proportions.

[2] U.S. Dept. of Commerce. Bureau of the Census. Series P-25, No. 922, Ibid.

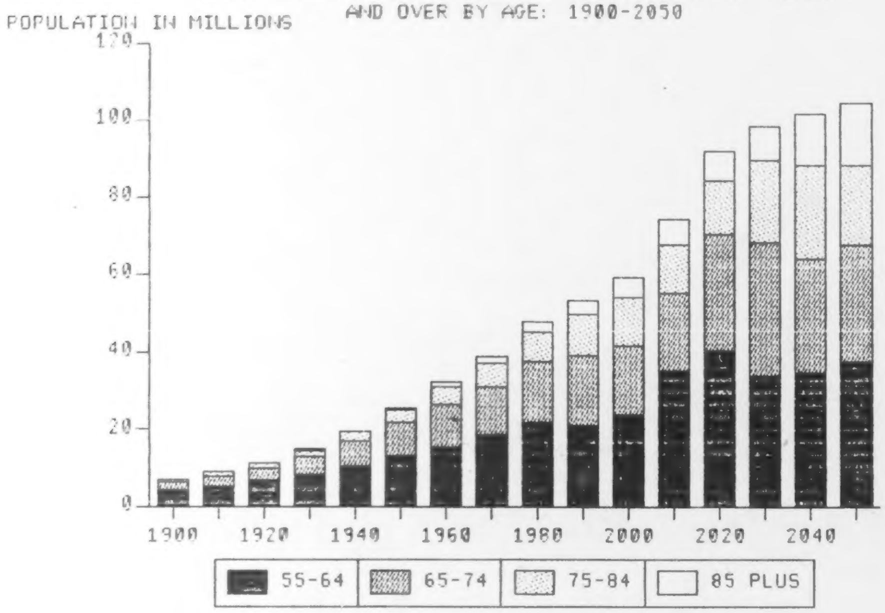
## TABLE 1.—THE GROWTH OF THE OLDER POPULATION, ACTUAL AND PROJECTED: 1900–2050

[Numbers in thousands]

| Year | Total population, all ages | | 55 years and over | | 55 to 64 years | | 65 to 74 years | | 75 to 84 years | | 85 years and over | | 65 years and over | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Number | Percent | Number | Percent | Number | Percent | Number | Percent | Number | Percent | Number | Percent | Number | Percent |
| 1900 | 76,303 | 100 | 7,093 | 9.3 | 4,009 | 5.3 | 2,189 | 2.9 | 772 | 1.0 | 123 | 0.2 | 3,084 | 4.0 |
| 1910 | 91,972 | 100 | 9,004 | 9.8 | 5,054 | 5.5 | 2,793 | 3.0 | 989 | 1.1 | 167 | .2 | 3,950 | 4.3 |
| 1920 | 105,711 | 100 | 11,465 | 10.8 | 6,532 | 6.2 | 3,464 | 3.3 | 1,259 | 1.2 | 210 | .2 | 4,933 | 4.7 |
| 1930 | 122,775 | 100 | 15,031 | 12.2 | 8,397 | 6.8 | 4,721 | 3.8 | 1,641 | 1.3 | 272 | .2 | 6,634 | 5.4 |
| 1940 | 131,669 | 100 | 19,591 | 14.9 | 10,572 | 8.0 | 6,375 | 4.8 | 2,278 | 1.7 | 365 | .3 | 9,019 | 6.8 |
| 1950 | 150,697 | 100 | 25,565 | 17.0 | 13,295 | 8.8 | 8,415 | 5.6 | 3,278 | 2.2 | 577 | .4 | 12,270 | 8.1 |
| 1960 | 179,323 | 100 | 32,132 | 17.9 | 15,572 | 8.7 | 10.997 | 6.1 | 4,633 | 2.6 | 929 | .5 | 16,560 | 9.2 |
| 1970 | 203,302 | 100 | 38,588 | 19.0 | 18,608 | 9.2 | 12,447 | 6.1 | 6,124 | 3.0 | 1,409 | .7 | 19,980 | 9.8 |
| 1980 | 226,505 | 100 | 47,244 | 20.9 | 21,700 | 9.6 | 15,578 | 6.9 | 7,727 | 3.4 | 2,240 | 1.0 | 25,544 | 11.3 |
| 1990 | 249,731 | 100 | 52,889 | 21.2 | 21,090 | 8.4 | 18,054 | 7.2 | 10,284 | 4.1 | 3,461 | 1.4 | 31,799 | 12.7 |
| 2000 | 267,990 | 100 | 58,815 | 21.9 | 23,779 | 8.9 | 17,693 | 6.6 | 12,207 | 4.6 | 5,136 | 1.9 | 35,036 | 13.1 |
| 2010 | 283,141 | 100 | 74,097 | 26.2 | 34,828 | 12.3 | 20,279 | 7.2 | 12,172 | 4.3 | 6,818 | 2.4 | 39,269 | 13.9 |
| 2020 | 296,339 | 100 | 91,629 | 30.9 | 40,243 | 13.6 | 29,769 | 10.0 | 14,280 | 4.8 | 7,337 | 2.5 | 51,386 | 17.3 |
| 2030 | 304,330 | 100 | 98,310 | 32.3 | 33,965 | 11.2 | 34,416 | 11.3 | 21,128 | 6.9 | 8,801 | 2.9 | 64,345 | 21.1 |
| 2040 | 307,952 | 100 | 101,307 | 32.9 | 34,664 | 11.3 | 29,168 | 9.5 | 24,529 | 8.0 | 12,946 | 4.2 | 66,643 | 21.6 |
| 2050 | 308,856 | 100 | 104,337 | 33.8 | 37,276 | 12.1 | 30,022 | 9.7 | 20,976 | 6.8 | 16,063 | 5.2 | 67,061 | 21.7 |

Source: U.S. Dept. of Commerce. Bureau of the Census. Decennial Censuses of Population, 1900–1980 and Projections of the Population of the United States: 1982 to 2050 (Advance Report). Current Population Reports, Series P-25, No. 922, October 1982. Projections are middle series.

CHART 1: ACTUAL AND PROJECTED POPULATION 55 YEARS AND OVER BY AGE: 1900-2050



SOURCE: U.S. CENSUS OF POPULATION, 1890-1980 AND PROJECTIONS OF THE POPULATION OF THE UNITED STATES: 1982 to 2050, CURRENT POPULATION REPORTS, SERIES P-25, NO. 922 MIDDLE SERIES

## 2. THE "AGED" AND "VERY OLD" POPULATIONS ARE THE FASTEST GROWING AGE GROUPS

The age groups which require special attention—and which will experience dramatic increases in numbers—are the aged and the very old. These groups are currently growing at a faster rate than any other age group in the American population. Less than 5 percent of the population was 75 or older in 1982; by 2030, almost 10 percent of the population is projected to be in that age group. By 2050, 12 percent of the entire population is expected to be 75 years or older.

Over the same timespan, the population aged 85 and over is projected to jump from about 1 percent to over 5 percent of the total population.

Overall, persons 85 and over are projected to be the fastest growing part of the older population. Chart 2 illustrates the dramatic increases in the number and proportion of the very old—from 123,000 in 1900, to 2.5 million in 1980, to a projected 16 million in 2050.

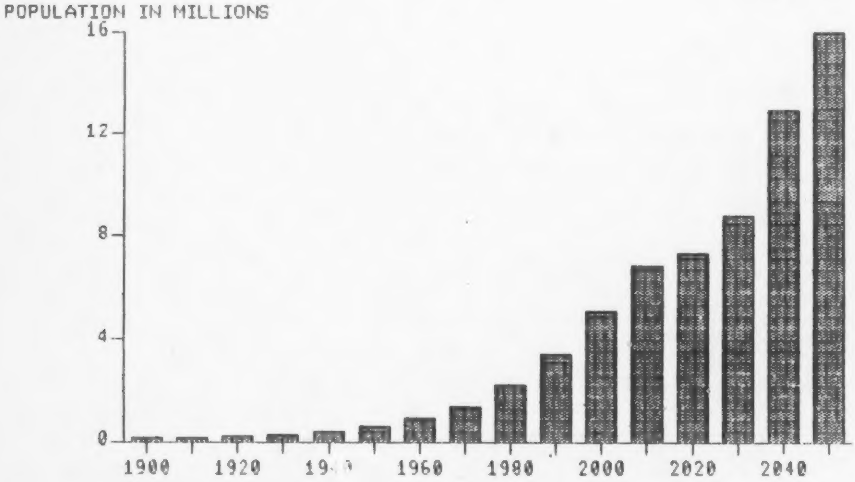
By 2010, in less than 30 years, the number of white males, white females, and black males 85 years and over is expected to increase

---

NOTE: The projections in this section and throughout this report are not forecasts of future patterns of growth or behavior. They represent the results of continued patterns from the past and other assumptions about future trends. They do not imply certainty about future events.

CHART 2

ACTUAL AND PROJECTED POPULATION 85 YEARS AND OLDER: 1900-2050



SOURCE: U.S. Dept. of Commerce. Bureau of the Census. Decennial Censuses, 1900-1980; and Current Population Reports, P-25 No. 922, Middle Series Projections.

about 1½ times while the number of black women in that group is expected to triple.

Because of the large number of persons who survive into their eighties, it is increasingly likely that older persons will themselves have a surviving parent. Four-generation families are becoming increasingly more common.

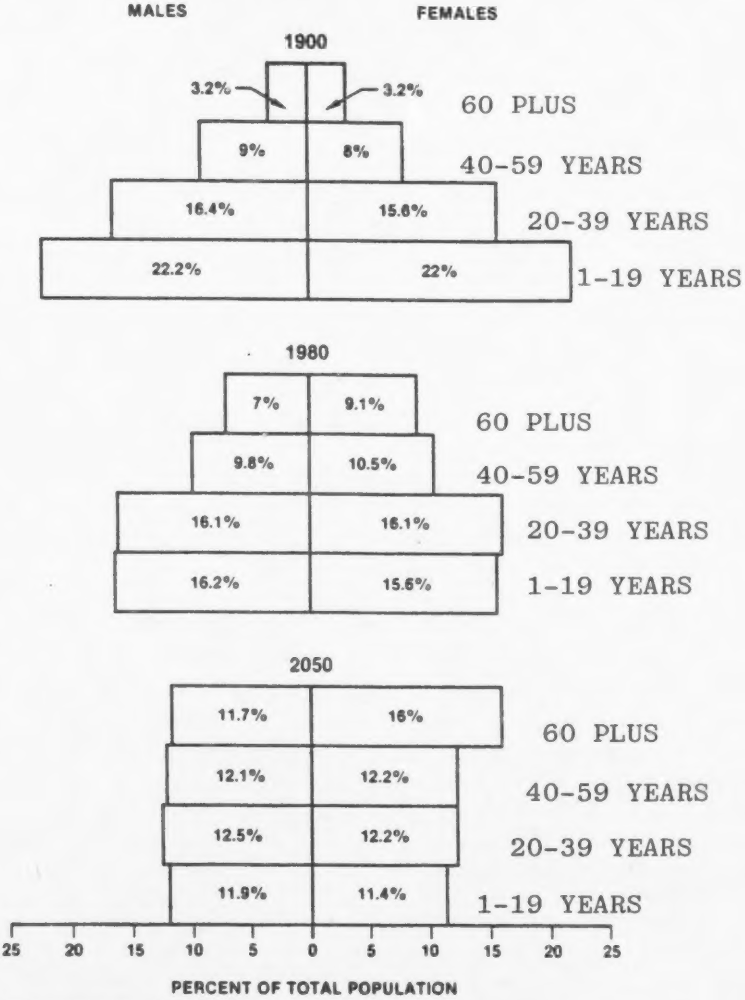
### 3. High Fertility Periods Are Primarily Responsible for the Aging of the Population

It is commonly assumed that the current growth of the older population is due to increased longevity. While a factor, the prime cause is a steady increase in the annual number of births in the years prior to 1920. Increases in longevity are, in fact, only a secondary cause of this shift. From 1920 to 1940, there was a drop in the number of births, accounting for the projected slowdown in the growth of the older population from 1990 to 2010. The post-World War II baby boom accounts for the projected rapid rise in the number of elderly from 2010 until 2030. After that, the growth rate will slow again because of low birth rates during the "baby bust" period from 1965 to 1973.

The dramatic impact that the increase in the older population has had and will continue to have on American society is illustrated in chart 3. At the turn of the century, a small portion—only 6.4 percent—of the population was 60 years and older, divided equally among males and females. Eight decades later, persons 60 years and older accounted for 16.1 percent of the population; 7 percent were men and 9.1 percent, women. In the next 80 years, a comparable surge in the older population will result in 27.7 percent of the population aged 60 years or older, 11.7 percent males and 16 percent females.[3]

Chart 3

**ACTUAL AND PROJECTED CHANGE IN POPULATION DISTRIBUTION 1900 - 2050**



NOTE: Projections are middle series.

SOURCE: U.S. Bureau of the Census, Decennial Censuses of Population, 1900-1980 and Projections of the Population of the United States; 1982 to 2050. Current Population Reports. Series P-25, No. 922, October, 1982.

---

[3] U.S. Dept. of Commerce. Bureau of the Census. Decennial Censuses of Population, 1900–1980 and Projections of the Population of the United States, 1982 to 2050. Current Population Reports, Series P-25, No. 922, October 1982.

## 4. THE PROPORTION OF ELDERLY IS LOWER AMONG NONWHITES THAN WHITES

The proportion of elderly persons in population groups varies considerably by race and ethnic origin. In 1982, about 12 percent of whites were 65 and over, 8 percent of blacks, 6 percent of Asians and Pacific Islanders, and 5 percent each of American Indians and Hispanics.

Over the last decade, the elderly white population grew by about 25 percent, but the elderly black population grew by over 30 percent. The elderly black population has grown at a faster rate than the white population partly as a result of higher black birth rates and partly as a result of the more rapid gains in life expectancy experienced by blacks than whites. In 1900, the average life expectancy at birth was 16 years higher for whites than for blacks; by 1978, the difference had been reduced to 5 years.

In 1982, 8.5 percent of the population 55 years and over was black (table 2); by 2050, blacks are projected to make up over 14 percent of the older population. The proportion of elderly in the total population varies by age and sex. In 1982, black men aged 85 and over were 7.6 percent of the total male population in that age group; black women aged 55 to 64 were 9.3 percent of all women that age. In 1982, white females 55 years and over constituted almost 11 percent of the total U.S. population, white males about 8 percent, black women just over 1 percent, and black men less than 1 percent.

TABLE 2.—POPULATION 55 YEARS AND OVER BY RACE AND SEX: 1982

[Numbers in thousands]

| | Total | | White | | Black | | Other races | |
|---|---|---|---|---|---|---|---|---|
| | Number | Percent | Number | Percent | Number | Percent | Number | Percent |
| Both sexes: | | | | | | | | |
| 0 to 54 | 183,069 | 100 | 154,459 | 84.4 | 23,590 | 12.9 | 5,018 | 2.7 |
| 55 plus | 48,930 | 100 | 44,078 | 90.1 | 4,148 | 8.5 | 704 | 1.4 |
| 55 to 64 | 22,096 | 100 | 19,780 | 89.5 | 1,953 | 8.8 | 363 | 1.7 |
| 65 to 74 | 16,129 | 100 | 14,531 | 90.1 | 1,380 | 8.5 | 218 | 1.4 |
| 75 to 84 | 8,239 | 100 | 7,495 | 91.0 | 646 | 7.8 | 98 | 1.2 |
| 85 plus | 2,466 | 100 | 2,272 | 92.1 | 169 | 6.9 | 24 | 1.0 |
| Male: | | | | | | | | |
| 0 to 54 | 91,820 | 100 | 77,909 | 85.0 | 11,428 | 12.4 | 2,482 | 2.7 |
| 55 plus | 21,105 | 100 | 19,043 | 90.2 | 1,737 | 8.2 | 325 | 1.6 |
| 55 to 64 | 10,329 | 100 | 9,300 | 90.0 | 861 | 8.3 | 167 | 1.6 |
| 65 to 74 | 6,996 | 100 | 6,318 | 90.3 | 576 | 8.2 | 102 | 1.5 |
| 75 to 84 | 3,053 | 100 | 2,761 | 90.4 | 245 | 8.0 | 47 | 1.5 |
| 85 plus | 728 | 100 | 664 | 91.2 | 55 | 7.6 | 9 | 1.2 |
| Female: | | | | | | | | |
| 0 to 54 | 91,247 | 100 | 76,552 | 84.0 | 12,160 | 13.3 | 2,536 | 2.8 |
| 55 plus | 27,825 | 100 | 25,036 | 90.0 | 2,410 | 8.7 | 379 | 1.4 |
| 55 to 64 | 11,768 | 100 | 10,480 | 89.1 | 1,092 | 9.3 | 196 | 1.7 |
| 65 to 74 | 9,133 | 100 | 8,213 | 89.9 | 804 | 8.8 | 116 | 1.3 |
| 75 to 84 | 5,183 | 100 | 4,734 | 91.3 | 400 | 7.7 | 52 | 1.0 |
| 85 plus | 1,738 | 100 | 1,609 | 92.6 | 114 | 6.6 | 15 | .9 |

Source: U.S. Dept. of Commerce. Bureau of the Census. Projections of the United States: 1982 to 2050 (Advance Report). Current Population Reports. Series P-25, No. 922, October 1982.

## 5. Older Women Outnumber Older Men

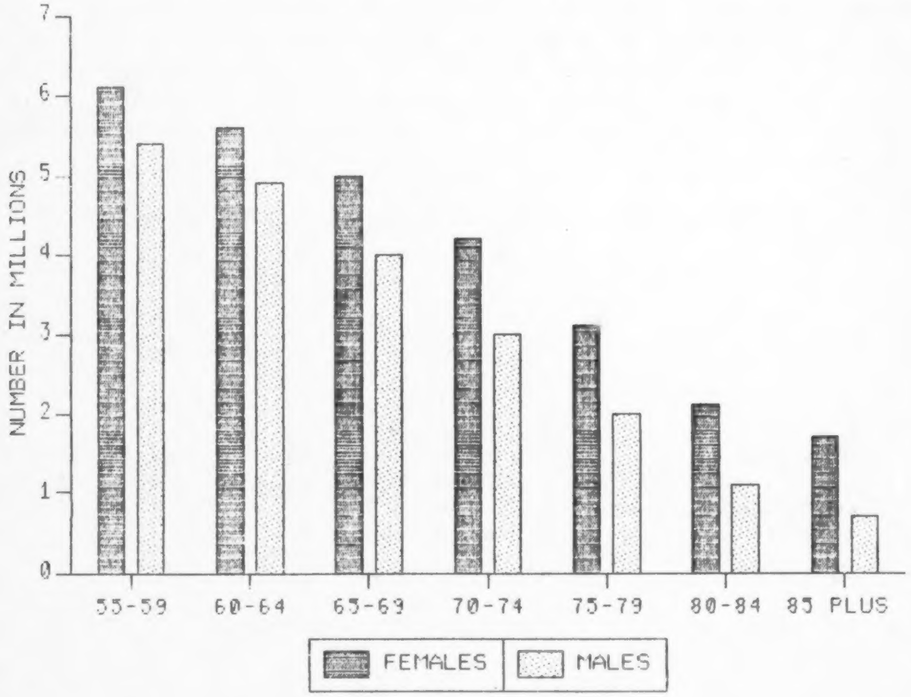
Elderly women now outnumber men 3 to 2, a considerable change from 1960 when elderly women outnumbered men by only 5 to 4.

Because the life expectancy of men is less than that of women, the health, social, and economic problems of the elderly, especially those over age 70, are predominantly the problems of women.[4]

In 1982, there were 80 men aged 65 to 69 years for every 100 females in that same age group, and 42 men aged 85 and over for every 100 females aged 85 and over (chart 4). These statistics emphasize the fact that the older woman has a high probability of living longer than the older man and, therefore, of living alone. Moreover, she is unlikely to remarry once she is widowed. The difference between the number of older men and women is significant within every age group.

Chart 4

POPULATION 55 YEARS AND OVER BY AGE AND SEX: 1982



SOURCE: U.S. Bureau of the Census, Current Population Reports, Series P-25, No. 922

---

[4] Siegel, Jacob S., and Sally L. Hoover. Demographic Aspects of the Health of the Elderly to the Year 2000 and Beyond. World Health Organization, WHO/AGE/82.3, July 1982. Prepared for the World Assembly on Aging, July-August 1982, Vienna, Austria. p. 22.

## 6. LIFE EXPECTANCY HAS IMPROVED DRAMATICALLY IN THIS CENTURY

An individual born in 1900 could expect to live an average of 49 years. By 1954, life expectancy at birth had jumped to 70 years; by 1982, it reached 74.5. In 1930, only 50 percent of all babies were expected to live to age 65; by 1982, over 75 percent of all newborns could expect to reach that age. Improvement in the years an individual could expect to live has been particularly significant for women. From 1940 to 1979, remaining life expectancy for males age 65 increased by only about 2 years (from 12.1 to 14.2 years); but for females it increased by 5 years (from 13.6 to 18.6 years) (chart 5).

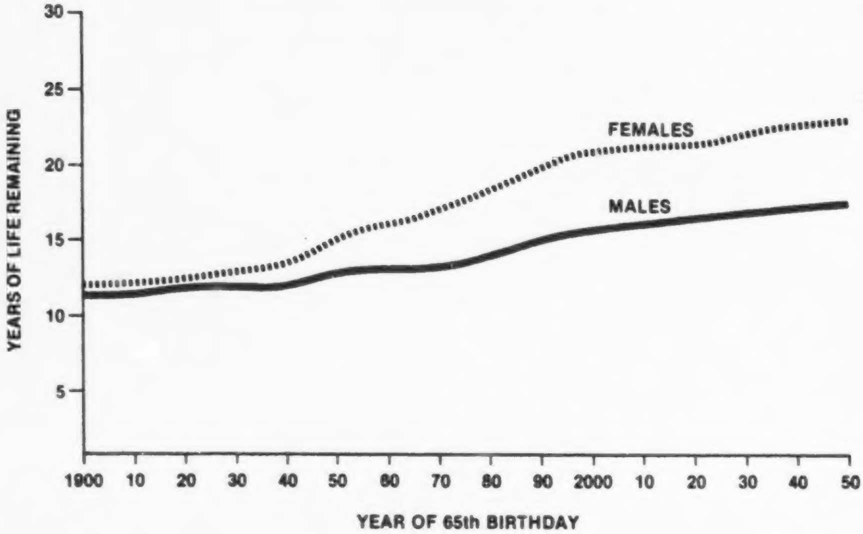
TABLE 3.—LIFE EXPECTANCIES AT BIRTH AND AGE 65 BY SEX AND CALENDAR YEAR

| | Male | | Female | |
|---|---|---|---|---|
| | At birth | At age 65 | At birth | At age 65 |
| Calendar year: | | | | |
| 1900 | 46.58 | 11.35 | 49.07 | 12.01 |
| 1910 | 50.20 | 11.38 | 53.67 | 12.10 |
| 1920 | 54.59 | 11.81 | 56.33 | 12.34 |
| 1930 | 58.01 | 11.38 | 61.36 | 12.91 |
| 1940 | 60.89 | 11.92 | 65.34 | 13.42 |
| 1950 | 65.33 | 12.81 | 70.90 | 15.07 |
| 1960 | 66.58 | 12.91 | 73.19 | 15.89 |
| 1970 | 67.05 | 13.14 | 74.80 | 17.12 |
| 1980 | 69.85 | 14.02 | 77.53 | 18.35 |
| 1990 | 72.29 | 15.11 | 79.85 | 19.92 |
| 2000 | 73.42 | 15.71 | 81.05 | 20.81 |
| 2010 | 73.93 | 15.08 | 81.62 | 21.27 |
| 2020 | 74.42 | 16.45 | 82.18 | 21.73 |
| 2030 | 74.90 | 16.81 | 82.74 | 22.18 |
| 2040 | 75.37 | 17.18 | 83.29 | 22.64 |
| 2050 | 75.84 | 17.55 | 83.84 | 23.11 |

Source: Social Security Administration, Office of the Actuary, September 1982.

Chart 5

LIFE EXPECTANCY AT AGE 65
1900 to 2050



SOURCE: Social Security Administration, Office of the Actuary
September, 1982

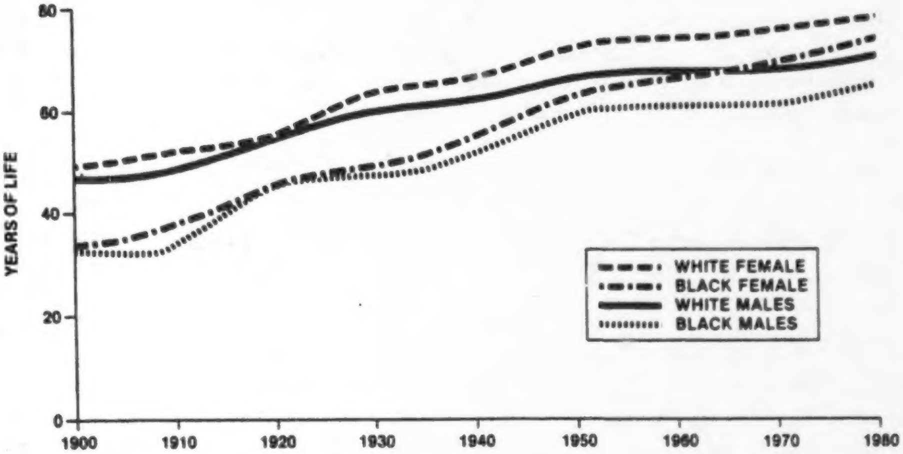
Life expectancy at birth differs according to race (chart 6). In 1940, the difference between whites and blacks was 11 years; by 1978, the difference had been reduced to 5 years. Much of the difference has been attributed to socioeconomic status.[5] The difference between blacks and whites in life expectancy at age 65, however, is small and has been for decades. In fact, death rates are higher for whites after age 80 than for blacks.

---

[5] Kitagawa, E. M., and P. M. Hauser. Differential Mortality in the United States: A Study in Socioeconomic Epidemiology. Cambridge, Harvard University Press, 1973. Chapters 2 and 8.

Chart 6

**EXPECTATION OF LIFE AT BIRTH BY RACE AND SEX**
**1900-1980**



SOURCE: U.S. Bureau of the Census, Historical Statistics of the United States, 1975 and National Center for Health Statistics, Monthly Vital Statistics, Vol. 29, No. 13, September, 1981.

An important measure of improvement in health and longevity is the frequency of deaths in the population, commonly called death or mortality rates. Dramatic improvements in the frequency of deaths in the population have been registered since 1940. Death rates declined rapidly from 1940 to 1954, changed little from 1955 to 1967, and again declined rapidly from 1968 to 1978. While death rates have fallen for both men and women, they have improved at a faster pace for women. In the 1968 to 1978 period, the average annual rate of decline in the mortality rate for those 65 and over was 1.5 percent for males and 2.3 percent for females. The largest improvements were for persons 65 to 69 and 85-plus years of age. The declines in this period were primarily a factor of reductions in deaths due to major cardiovascular diseases.[6]

Male and female differences in longevity have steadily increased, from a disparity in the age-adjusted death rates of 22 percent in favor of females in 1940, to a difference of 73 percent in favor of females by 1978.[7] Whether this difference is due to environmental or genetic factors has yet to be determined.

---

[6] Manton, Kenneth G., and Eric Stallard. Temporal Trends in U.S. Multiple Cause of Death Mortality Data: 1968 to 1977. Demography, v. 19, No. 4, November 1982, pp. 527-547.

[7] U.S. Dept. of Health and Human Service. Public Health Service. National Center for Health Statistics. Changes in Mortality Among the Elderly, United States 1940-1978, Vital and Health Statistics. Series 3, No. 22. DHHS pub. No. (PHS) 892-1406, March 1982. Washington, U.S. Govt. Print. Off. pp. 2-5

Not only do mortality trends have major implications for the numbers and proportion of elderly in the future American population, but they also affect the need for health and social services among the older population. Decreases in mortality rates do not necessarily translate into better health for all those living longer. Rather, the projected rapid increase in the size of the older population, particularly the very old, implies related increases in the demand for health care delivery and assistance. And, if the onset of limitations due to chronic disease were delayed rather than shortened, health costs could exceed even current projections.

## 7. RATIO OF RETIRED TO WORKING AGE PERSONS IS INCREASING DRAMATICALLY

The combined effect of decreased fertility levels and increased numbers of elderly persons will result in growth in the ratio of elderly persons compared to persons of working age (18 to 64 years of age). In 1900, there were about 7 elderly persons for every 100 persons 18 to 64 years; by 1982, that ratio was almost 19 elderly persons per 100 of working age. By 2010, that ratio is expected to be 22 per 100, and to increase rapidly to 38 per 100 by 2050. This ratio is often referred to as a "support ratio." The ratio reflects the economic fact that the working population "supports" nonworking age groups. While the total support ratio has declined since 1900, the marked increase in the aged support ratio (in contrast with the decline in the young support ratio) is especially important since it is primarily publicly funded programs which serve this age group. Moreover, the previously noted dramatic growth in the very old age group, with relatively greater health, social maintenance, housing, and other economic needs, will require proportionately higher levels of "support" than is true today (table 4, chart 7).

TABLE 4.—THE ABSOLUTE AND RELATIVE SIZE OF THE 65-PLUS POPULATION

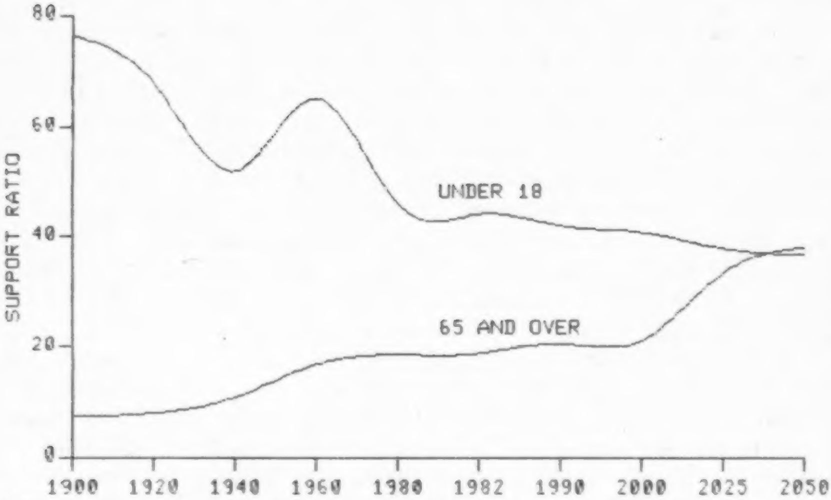
| | Number of 65-plus (millions) | Cumulative percent increase | 65-plus as a percent of population | Aged support ratio [1] | Total support ratio | Elderly age groups as a percent of total 65-plus population | | |
|---|---|---|---|---|---|---|---|---|
| | | | | | | 65 to 75 | 75 to 84 | 85-plus |
| Year: | | | | | | | | |
| 1960 | 16.6 | | 9.2 | 16.84 | 81.95 | 66.4 | 28.0 | 5.6 |
| 1980 | 25.5 | 54 | 11.3 | 18.59 | 64.39 | 61.0 | 30.2 | 8.8 |
| 1990 | 31.8 | 79 | 12.7 | 20.70 | 62.57 | 56.8 | 32.3 | 10.9 |
| 2000 | 35.0 | 88 | 13.1 | 21.16 | 61.86 | 50.5 | 34.8 | 14.7 |
| 2025 | 58.6 | 155 | 19.5 | 33.31 | 71.00 | 56.4 | 30.5 | 13.1 |
| 2050 | 67.1 | 170 | 21.7 | 37.85 | 74.76 | 44.8 | 31.3 | 24.0 |

[1] Ratio of 65-plus to working age population, 19 to 64 years.

Source: U.S. Dept. of Commerce. Bureau of the Census. Projections of the United States: 1982 to 2050 (Advance Report). Series P–25, No. 922, October 1982; and Estimates of the Population of the United States by Single Years of Age, Color, and Sex, 1900 to 1959. Series P–25, No. 311, July 2, 1965; and Series P–25, No. 310, June 30, 1965. Projections are the middle series.

Chart 7

YOUNG AND ELDERLY SUPPORT RATIO FOR 1900-2050



SOURCE: U.S. Bureau of the Census, Current Population Reports, Series P-25, No. 922, No. 310 and No. 311. Projections are the middle series.

NOTE: "Young support ratio is the number of persons under 18 per 100 aged 18-64 years. "Elderly" support ratio is the number 65+ per 100 aged 18-64 years.

## 8. THE MAJORITY OF ELDERLY PERSONS LIVE IN METROPOLITAN AREAS

At the time of the 1980 census, almost two-thirds of the elderly population lived in metropolitan areas and 10 percent of the country's metropolitan areas were elderly.

Elderly persons are less likely to live in the suburbs than are persons under age 65 (34 versus 41 percent), although older white persons are more likely to live in the suburbs than older black or Hispanic persons.

## 9. THE GEOGRAPHIC DISTRIBUTION OF THE ELDERLY POPULATION IS SHIFTING TO RURAL, SMALL TOWNS, AND RETIREMENT AREAS

At the same time that the majority of 65-plus persons live in metropolitan areas, growth of the elderly population in small towns and rural areas has been about 2.5 percent annually in recent years.[8]

Counties with a high percentage of elderly are distributed all across the country (map 1). There are now over 500 rural and small-town counties in which persons 65 and over make up at least 16 percent of the total population; in 178 counties the elderly make up over 20 percent of the total population. Over 50 percent of these counties, especially in the Nation's heartland, are agricultural areas where the older population has stayed on while the younger generation has moved out. Heavy outmigration of the young plus relatively low fertility in some areas contributed to a high proportion of elderly in Iowa, Kansas, Missouri, Nebraska, South Dakota, Arkansas, Maine, Massachusetts, Rhode Island, and Pennsylvania. The remainder of the counties with an exceptionally high proportion of elderly are retirement areas to which the older population have relocated, such as those in Florida, the Ozark Plateau, and the Texas Hill Country. The number of areas attracting inmigration from retirees has expanded considerably since the 1950's and now extends beyond the Sun Belt (map 2).

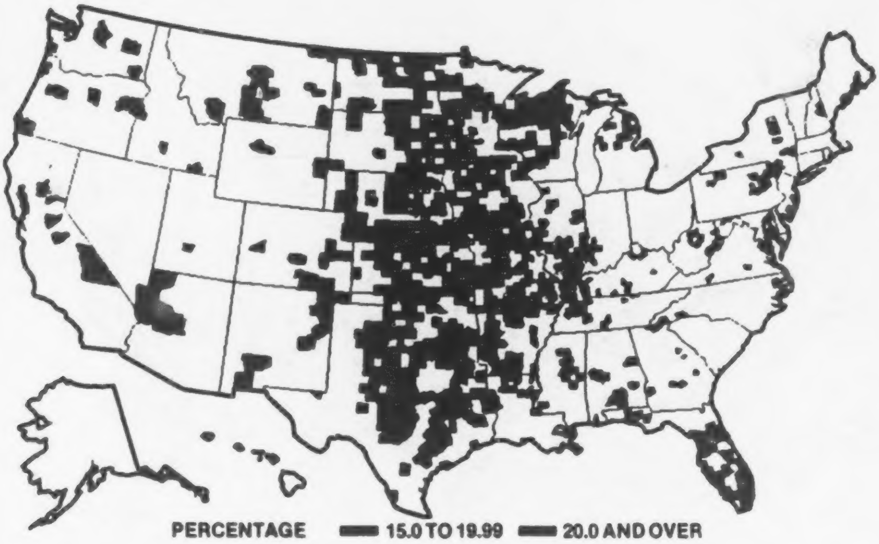
---

[8] U.S. Congress. Senate. Special Committee on Aging. Calvin L. Beale, Rural Older Americans: Unanswered Questions. Hearing. 97th Cong., 2d Sess. May 19, 1982. Washington, U.S. Govt. Print. Off.

In 1980, there were seven States with more than 1 million persons 65 years and over: California (2.4 million); New York (2.2 million); Florida (1.7 million); Pennsylvania (1.6 million); Texas (1.4 million); Illinois (1.3 million); and Ohio (1.2 million). With the inclusion of Michigan, almost 50 percent of the total elderly population of the United States is accounted for in these eight States (table 5). Alaska had the smallest number of elderly persons—only 11,500—less than 3 percent of its total population. Florida is the State with the largest percentage (17.3) of citizens over 65 in the population. Arkansas, Rhode Island, Iowa, Missouri, South Dakota, Nebraska, and Kansas followed with 13 to 14 percent. Most States had at least a 50-percent increase in the number of persons 85 and over in the last decade while Arizona, Florida, and Nevada more than doubled the size of their very old population. Nevada experienced the largest increase of persons 65 and over, 113 percent, and New York the smallest, 10.8 percent.

Map 1

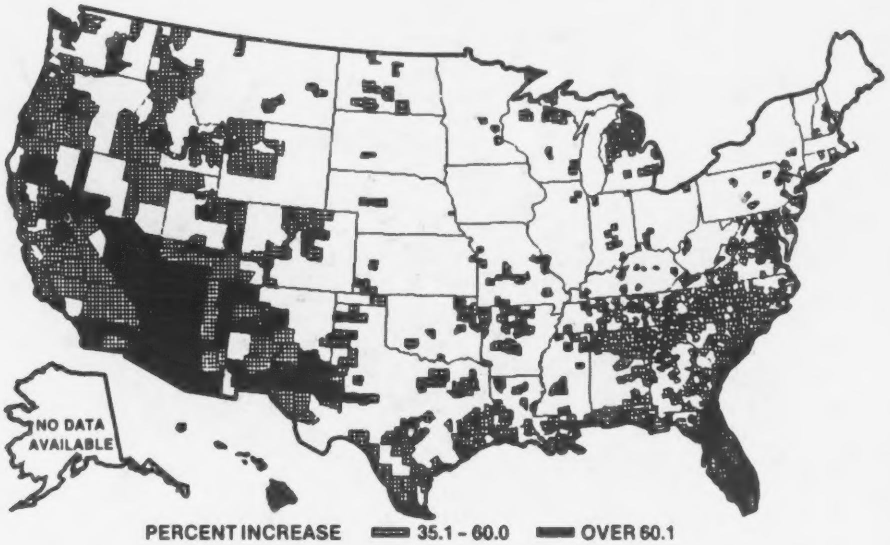
PERCENTAGE OF POPULATION 65 YEARS AND OLDER
COUNTIES WITH 15 PERCENT OR MORE
1980


PERCENTAGE
▬ 15.0 TO 19.99
▬ 20.0 AND OVER

SOURCE: U.S. Bureau of the Census, Decennial Census of the Population, 1980.

Map 2

**AGING POPULATION GROWTH
COUNTIES WITH 35 PERCENT OR MORE INCREASE
IN RESIDENTS 65 YEARS AND OLDER
1970-1980**



SOURCE: U.S. Bureau of the Census, Decennial Census of the Population, 1970 and 1980.

The traditional notion of Florida as the State with the greatest concentration of elderly persons is borne out by the statistics. The three large metropolitan areas in 1980 with the greatest proportion of elderly in the United States were all in Florida—more than 20 percent of the population of the Fort Lauderdale-Hollywood and Tampa-St. Petersburg metropolitan areas were elderly. In the Miami area, one in six persons was elderly. These three metropolitan areas also had the largest proportions 75-plus (7 to 8 percent) and 85-plus (1.3 to 1.7 percent) although these proportions were not much above the national average. The smallest proportion of metropolitan elderly were in Houston, Tex., with less than 7 percent elderly. Only the New York metropolitan area had over 1 million elderly residents.

### 10. Older Persons Change Residences About Half as Often as the Younger Population, but Those Who Move Tend To Migrate to the Sun Belt

Most older persons remain in the same place where they spent most of their adult lives. Between 1975 and 1980 the older population who moved from one house to another did so at about half the rate of the population of all ages. During this time, about 25 percent of the population 55 to 64 years old and about 20 percent of the population 65 years or older moved, compared with 45 percent of the population age 5 and over.

While about 9 percent of the population age 5 and over relocated to a different State, only a little over 4 percent of the elderly population did so. However, preliminary estimates from the retirement migration project, analyzing data from the U.S. Bureau of the Census, demonstrate that the number of elderly who reported migrating from State to State rose sharply from 1970 to 1980. The increase in the number of elderly migrants in the last decade was four times the increase reported from 1960 to 1970. Of the 1,662,520 Americans over the age of 60 who moved, nearly half went to five States: Florida, California, Arizona, Texas, and New Jersey. Three States had an especially rapid increase in the numbers of persons over 60 who moved from 1960 to 1980. Arizona had a 215 percent increase, Texas had a 191 percent increase, and Florida a 110 percent increase. Florida captured over one-fourth of all the interstate migrants over age 60 during the last two decades, according to the results of the study. Preliminary results of the study also showed that elderly migrants are relatively affluent, relatively well educated, and frequently accompanied by spouses.

TABLE 5.—NUMBER AND PERCENTAGE OF EACH STATE'S TOTAL POPULATION AGED 65 AND OVER: 1980

[Numbers in thousands]

| State | All ages | | 65 and over | | | | Percent increase 1970–80 |
|---|---|---|---|---|---|---|---|
| | Number | Rank | Number | Rank | Percent | Rank | |
| Alabama | 3,894 | 22 | 440 | 19 | 11.3 | 24 | 35.0 |
| Alaska | 402 | 51 | 12 | 51 | 2.9 | 51 | 67.7 |
| Arizona | 2,718 | 29 | 307 | 28 | 11.3 | 25 | 90.4 |
| Arkansas | 2,286 | 33 | 312 | 27 | 13.7 | 2 | 31.4 |
| California | 23,668 | 1 | 2,414 | 1 | 10.2 | 34 | 34.1 |
| Colorado | 2,890 | 28 | 247 | 33 | 8.6 | 46 | 31.6 |
| Connecticut | 3,108 | 25 | 365 | 26 | 11.7 | 18 | 26.3 |
| Delaware | 594 | 48 | 59 | 48 | 10.0 | 36 | 35.0 |
| District of Columbia | 638 | 47 | 74 | 46 | 11.6 | 20 | 4.9 |
| Florida | 9,746 | 7 | 1,688 | 3 | 17.3 | 1 | 70.6 |
| Georgia | 5,463 | 13 | 517 | 16 | 9.5 | 41 | 40.6 |
| Hawaii | 965 | 39 | 76 | 45 | 7.9 | 49 | 72.4 |
| Idaho | 944 | 41 | 94 | 41 | 9.9 | 37 | 38.2 |
| Illinois | 11,427 | 5 | 1,262 | 6 | 11.0 | 29 | 15.4 |
| Indiana | 5,490 | 12 | 585 | 13 | 10.7 | 31 | 18.5 |
| Iowa | 2,913 | 27 | 388 | 24 | 13.3 | 4 | 10.7 |
| Kansas | 2,364 | 32 | 306 | 29 | 13.0 | 8 | 15.1 |
| Kentucky | 3,661 | 23 | 410 | 21 | 11.2 | 27 | 21.5 |
| Louisiana | 4,206 | 19 | 404 | 22 | 9.6 | 39 | 31.8 |
| Maine | 1,125 | 38 | 141 | 36 | 12.5 | 11 | 23.0 |
| Maryland | 4,217 | 18 | 396 | 23 | 9.4 | 42 | 32.0 |
| Massachusetts | 5,737 | 11 | 727 | 10 | 12.7 | 10 | 14.2 |
| Michigan | 9,262 | 8 | 912 | 8 | 9.9 | 38 | 21.2 |
| Minnesota | 4,076 | 21 | 480 | 18 | 11.8 | 17 | 17.3 |
| Mississippi | 2,521 | 31 | 289 | 31 | 11.5 | 21 | 30.1 |
| Missouri | 4,917 | 15 | 648 | 11 | 13.2 | 5 | 15.6 |
| Montana | 787 | 44 | 85 | 43 | 10.8 | 32 | 23.0 |
| Nebraska | 1,570 | 35 | 206 | 35 | 13.1 | 7 | 12.1 |
| Nevada | 800 | 43 | 66 | 47 | 8.2 | 47 | 112.3 |
| New Hampshire | 921 | 42 | 103 | 40 | 11.2 | 28 | 31.3 |
| New Jersey | 7,365 | 9 | 860 | 9 | 11.7 | 19 | 23.4 |
| New Mexico | 1,303 | 37 | 116 | 38 | 8.9 | 45 | 64.2 |

## TABLE 5.—NUMBER AND PERCENTAGE OF EACH STATE'S TOTAL POPULATION AGED 65 AND OVER: 1980—Continued

[Numbers in thousands]

| State | All ages | | 65 and over | | | | Percent increase 1970–80 |
|---|---|---|---|---|---|---|---|
| | Number | Rank | Number | Rank | Percent | Rank | |
| New York | 17,558 | 2 | 2,161 | 2 | 12.3 | 13 | 10.2 |
| North Carolina | 5,882 | 10 | 603 | 12 | 10.2 | 35 | 45.7 |
| North Dakota | 653 | 46 | 80 | 44 | 12.3 | 14 | 21.2 |
| Ohio | 10,798 | 6 | 1,169 | 7 | 10.8 | 30 | 17.2 |
| Oklahoma | 3,025 | 26 | 376 | 25 | 12.4 | 12 | 25.5 |
| Oregon | 2,633 | 30 | 303 | 30 | 11.5 | 22 | 33.8 |
| Pennsylvania | 11,864 | 4 | 1,531 | 4 | 12.9 | 9 | 20.3 |
| Rhode Island | 947 | 40 | 127 | 37 | 13.4 | 3 | 22.1 |
| South Carolina | 3,122 | 24 | 287 | 32 | 9.2 | 44 | 50.5 |
| South Dakota | 691 | 45 | 91 | 42 | 13.2 | 6 | 13.1 |
| Tennessee | 4,591 | 17 | 518 | 15 | 11.3 | 26 | 34.8 |
| Texas | 14,229 | 3 | 1,371 | 5 | 9.6 | 40 | 38.2 |
| Utah | 1,461 | 36 | 109 | 39 | 7.5 | 50 | 40.8 |
| Vermont | 511 | 49 | 58 | 49 | 11.4 | 23 | 22.5 |
| Virginia | 5,346 | 14 | 505 | 17 | 9.5 | 43 | 38.1 |
| Washington | 4,132 | 20 | 432 | 20 | 10.4 | 33 | 34.0 |
| West Virginia | 1,950 | 34 | 238 | 34 | 12.2 | 15 | 22.3 |
| Wisconsin | 4,705 | 16 | 564 | 14 | 12.0 | 16 | 19.3 |
| Wyoming | 470 | 50 | 37 | 50 | 7.9 | 48 | 23.1 |

Source: U.S. Bureau of the Census, 1980 census.

At the same time that migration of the elderly from State to State has increased, about 50 percent of all movement of the older population is within the same metropolitan area and does not involve a major relocation. For example, between 1975 to 1980, older persons who had lived in the central city tended to move to another location in the same central city and persons who lived in the suburbs tended to move someplace else within the suburban area. Another 50 percent of elderly movers moved from a suburban area to the central city. From 1975 to 1980, a net average of 45,000 elderly persons moved to rural areas and small towns each year. Persons aged 55 to 74 years old were almost three times as likely to move from a metropolitan to a nonmetropolitan area as the reverse; but for persons 75 and over, migration streams in each direction were equally likely. A variety of factors—medical care, decreased physical mobility, the onset of widowhood, and the wish to be near family—may explain this shift for those over 75.

Of those who are 65 years and over, unmarried persons are more likely to move than are married persons, those in the labor force are less likely to move than those not working, the better educated are more likely to move, and the majority of elderly families receiving assistance income tend not to move. Further, many older persons who move to nonmetropolitan areas are motivated by positive images of rural or small town life, or negative views of metropolitan life. Most have preexisting ties to the new area, such as family, friends, or property.[9]

---

[9] Ibid.

## 11. THE AGING OF POPULATIONS IS AN INTERNATIONAL PHENOMENON

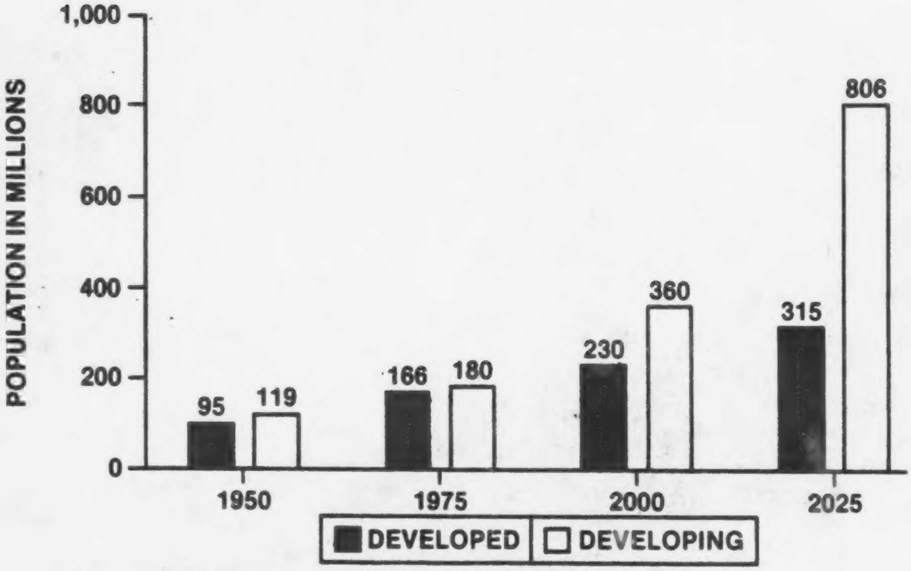
All world regions are witnessing an increase in the absolute and relative size of their older population. Until recently, the aged have represented a relatively small proportion of most country's populations and were not the primary focus of social and economic resources.

Historically, the attention of educators, scientists, and government officials in most countries has been directed toward early childhood and youth, but this is no longer the case.

The number of older persons in the world is expected to increase from 376 million in 1980 to 1,121 million in 2025 and the proportion of older persons in the total world population is expected to increase from 8.5 to 13.7 percent over that period. This will result in a world population in which one out of every seven individuals will be 60 years of age or older by the year 2025.[10]

Chart 8

WORLD POPULATION 60 YEARS AND OLDER FOR DEVELOPED AND DEVELOPING COUNTRIES 1950-2025



SOURCE: United Nations World Assembly on Aging Introductory Document: Demographic Considerations, Report of the Secretary General, 1982.

There is a substantial difference in the projected rates of aging of the population in developed (industrialized) and developing (nonindustrialized) countries. In fact, the 1980's marks a turning point in which the number of people 60 years and older are about evenly divided between developed and developing countries (48 and 52 percent). However, by the year 2025, the 60-plus group is expected to equal 315 million in the developed regions and 806 million in the developing regions. This will mean that only 28 percent of the world's older persons will reside in currently industrialized countries, while 72 percent will reside in developing countries.

---

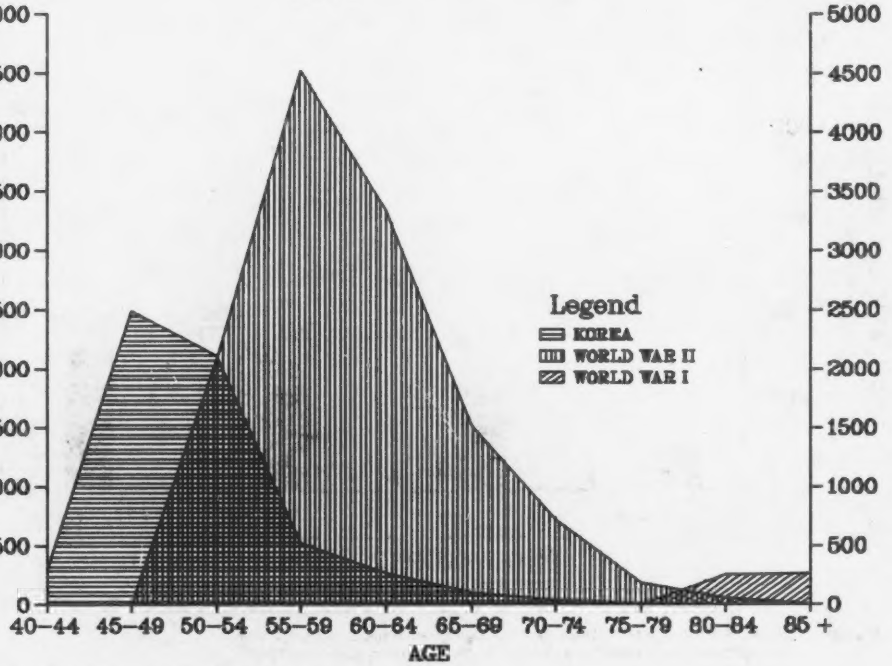
[10] U.N. World Assembly on Aging Introductory Document: Demographic Considerations, Report of the Secretary General, 1982.

### 12. LARGE NUMBERS OF VETERANS WILL ENTER THE OLDER AGE GROUP IN THIS CENTURY

Over two centuries of American history, the United States has been involved in 10 major armed conflicts. Nearly 39 million Americans have participated in these wars and over 90 percent have served during this century. Presently, the living veteran population stands at just over 30 million and the Veterans Administration operates the largest health care system in the United States.[11]

Chart 9

ESTIMATED NUMBER OF VETERANS BY
AGE AND PERIOD OF SERVICE
1980



Source: Veterans Administration, Research Division.

---

[11] U.S. Dept. of Commerce. Bureau of the Census. Current Population Reports. Series P-60, No. 140, July 1983. Figures based upon income of all persons age 65 and over, whether or not they are part of the labor force. Income of females would be comparatively higher if only those part of the labor force were counted.

The average age of veterans in civilian life is presently about 48 years. (The average age of female veterans is somewhat lower—46.2 years.) As a result of the large number of World War II veterans who will enter the older age ranges, this figure will increase by about 6 years over the next two decades, provided no large buildup of the Armed Forces will be required.

By the year 2000 two out of three veterans, close to 9 million persons, will be elderly. This will result in a dramatic, although relatively short term, burden on the Veterans Administration health care system as large numbers of veterans enter the upper age groups by the beginning of the next century.

## B. INCOME AND POVERTY

The economic position of elderly persons, in general, is at a considerably lower level and is much less secure than that of the younger population. Only a minority manage to maintain relatively high incomes throughout their later years. Lower incomes in the elderly population are associated with factors over which elderly persons themselves have little control: Their sex and race, the health and survival of their spouses, and their own health and ability to continue to work at acceptable wages. There is a strong pattern of declining income associated with advancing age. However, older people who work full time tend to have incomes similar to younger persons of the same race and sex. For many elderly who do not work, social security payments are vital. The paragraphs which follow discuss more specifically the factors which affect the income levels of elderly persons, the most important sources of income, and poverty levels.[12]

### 1. OLDER AGE IS ASSOCIATED WITH SIGNIFICANTLY LOWER INCOME LEVELS

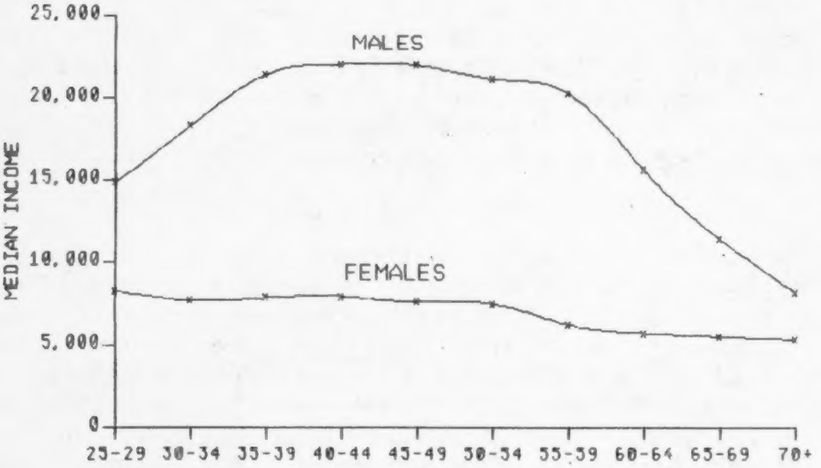
Income tends to increase with age until about 55, when significant numbers of people begin to retire and a steady decline in average income level begins (chart 10). For example, the median income in 1982 of men aged 60 to 64 years was almost three-fourths that of men 15 years younger ($15,536 versus $21,952) but almost double that of men aged 65 and over ($9,188). The pattern for women is much the same, although the decline in income begins earlier (at age 50) and starts out at much lower levels. Elderly women had a median income in 1982 of $5,365, compared with about $7,418 for women aged 25 to 64 years. The median income for all elderly persons was $6,593, compared with $12,387 for persons age 25 to 64. Chart 11 shows the relatively greater proportion of elderly in lower income brackets, and the much smaller proportion receiving incomes above $10,000 than is the case with the population aged 15 to 64.

---

[12] Current data are from the March 1983 Current Population Survey and refer to money income in 1982 for the noninstitutionalized population only.

Chart 10

MEDIAN INCOME OF PERSONS 25 YEARS AND OVER BY SEX AND AGE
1982

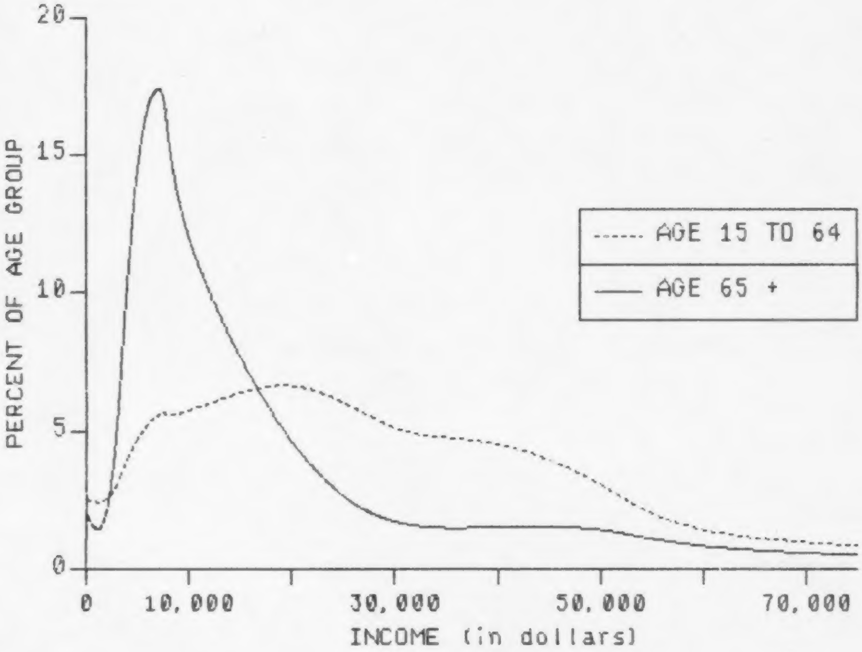


SOURCE: Bureau of the Census, Current Population Reports, Series P-60, No. 140 and unpublished data

A number of income experts have cautioned against interpreting cross-sectional income data as indicative of lifetime earning patterns for individual workers. However, presently available data does strongly reflect a drop in income at retirement age and beyond.

Chart 11

TOTAL CASH HOUSEHOLD INCOME, BY AGE GROUP
(PERCENT DISTRIBUTION)
1982



SOURCE: U.S. Bureau of the Census, Current Population Survey March 1983; Compiled by Congressional Research Service.

## 2. Incomes of the Elderly Keep Up With Inflation Better Than Incomes of Younger Persons

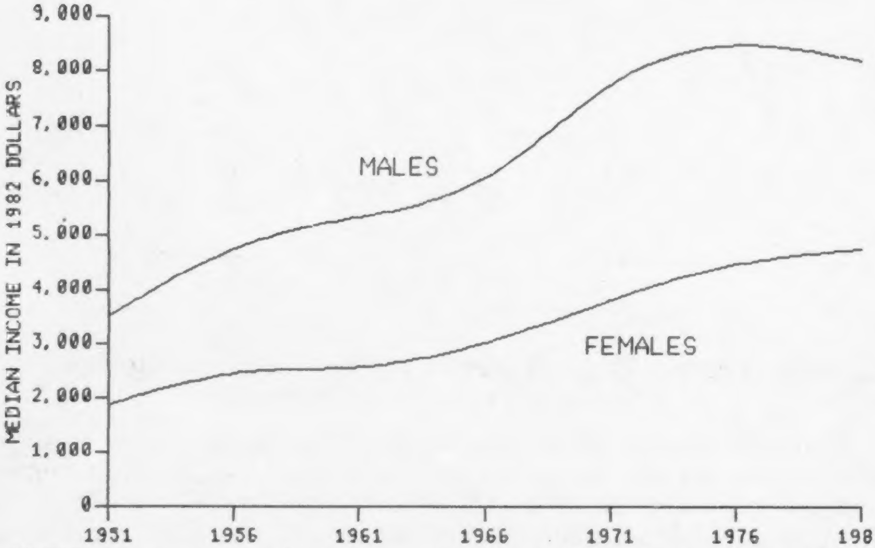
While the income levels of most elderly persons are low in an absolute sense, as well as in comparison to the younger adult population, inflation did not affect the elderly population as much as the younger population. Real median incomes of the elderly remained about constant from 1980 to 1982, a reflection in part of the indexing of many sources of retirement income to the Consumer Price Index. For the younger population, on the other hand, median income dropped a few percent from the 1980 level. In 1972, a major "catchup" increase was enacted in social security benefits and as a result the median incomes of the elderly grew at about double the rate of those for younger people over the past decade. Using constant dollars, the median income of elderly persons has more than doubled since 1951 (table 6, chart 12).

TABLE 6.—MEDIAN INCOME (IN CONSTANT 1982 DOLLARS) OF PERSONS 65 YEARS AND OVER: 1951–82

| | Male | | Female | |
|---|---|---|---|---|
| | Current dollars | 1982 dollars | Current dollars | 1982 dollars |
| Year: | | | | |
| 1982 | $9,188 | $9,188 | $5,365 | $5,365 |
| 1981 | 8,173 | 8,671 | 4,757 | 5,047 |
| 1976 | 5,293 | 8,977 | 2,816 | 4,776 |
| 1971 | 3,449 | 8,218 | 1,706 | 4,065 |
| 1966 | 2,162 | 6,430 | 1,085 | 3,227 |
| 1961 | 1,758 | 5,705 | 854 | 2,771 |
| 1956 | 1,421 | 5,047 | 738 | 2,621 |
| 1951 | 1,008 | 3,746 | 536 | 1,992 |

Chart 12

MEDIAN INCOME IN CONSTANT DOLLARS
FOR MALES AND FEMALES 65 YEARS AND OVER
FOR SELECTED YEARS



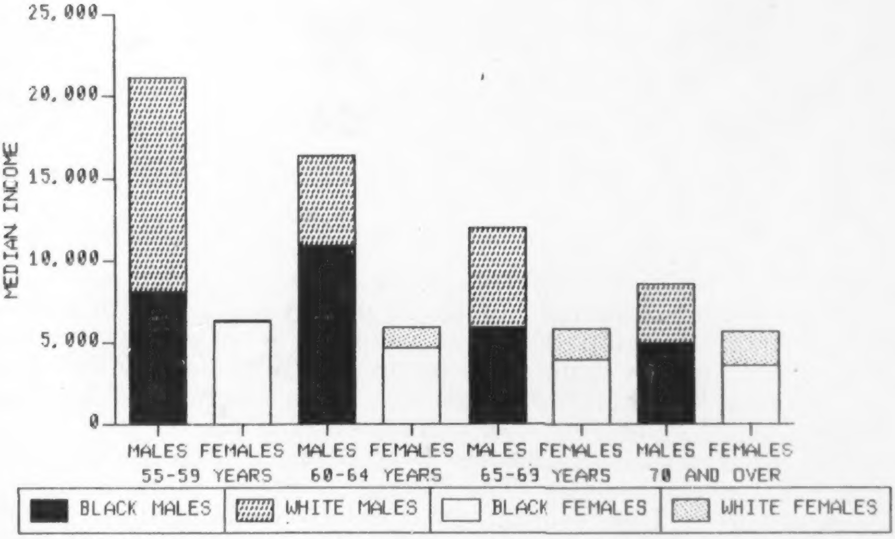
SOURCE: Bureau of the Census, Current Population Report, Series P-60
1982 constant dollars computed

### 3. Minorities and Women Have Lower Incomes

Within the elderly population, income differences between men and women, and between whites and blacks, are striking. The income level of women, for all age groups, is much less than that of men of the same race. White men tend to have the highest median incomes and black women the lowest. In 1982, elderly white men aged 65 to 69 had median incomes of about $11,900; white women, $5,700; black men, $5,900; and black women, $3,900 (chart 13). Contrary to the popular notion of the older rich widow, the statistics show that wealthy widows are a very small proportion of the elderly: Out of 14 million older white women, only 61,000 had incomes greater than $50,000, and only 31,000 of these were widows. As already indicated, the high-income elderly population is relatively small but white males are by far the most likely to be in this group. Almost 8 percent of elderly white males had incomes greater than $30,000 in 1982 compared with 2 percent for white females.

Chart 13

MEDIAN ANNUAL INCOMES
OF PERSONS 55 YEARS AND OVER BY AGE, RACE AND SEX- 1982



SOURCE: Bureau of the Census, Current Population Survey, March 1982 unpublished

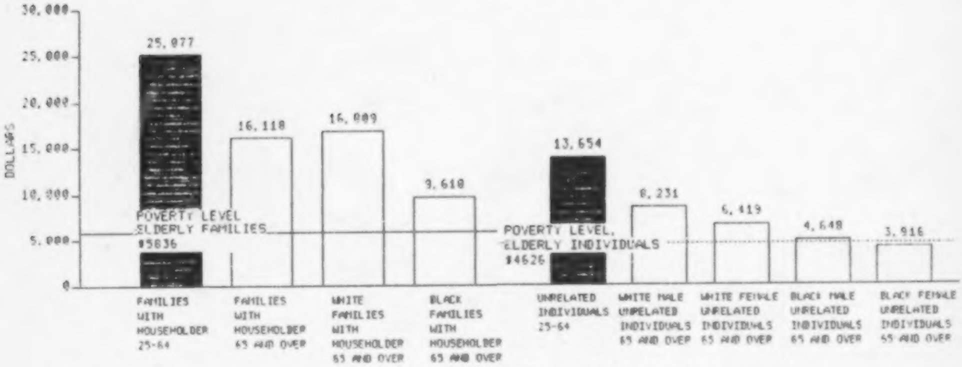
Comparisons of income between elderly persons living alone and those living as part of a family or as part of multiperson households show that those living alone receive much less income. Some of the per person difference is undoubtedly due to the fact that those not part of a family are older, and older persons currently have lower incomes on the average than younger persons. But much of the difference is due to the loss of a spouse and the alteration of stable and supporting living arrangements, and the loss of income from work.

In 1982, there were 9.6 million families maintained by a person 65 years old or over. The median income of elderly families for that year was $16,118 (chart 14), which was much lower than that of younger families. But elderly families tend to be smaller than younger families, and when family size is taken into account, the median income of the elderly family was about 95 percent of that of all families in 1982. The relative position of elderly families has improved considerably since 1970, when they had a median income adjusted for family size of about 77 percent of that of all families.

Much of this improvement is due to increases in social security benefits enacted in the 1970's.

Chart 14

MEDIAN INCOME OF ELDERLY FAMILIES AND INDIVIDUALS COMPARED TO THE POVERTY LEVEL AND THE MEDIAN OF YOUNGER FAMILIES AND INDIVIDUALS 1982



SOURCE: Bureau of the Census, Current Pop. Reports, P-60, No. 134

There are a substantial number of elderly families with incomes at the lowest economic levels as compared with younger families. In 1982, of families maintained by an elderly person, 25 out of 100 had incomes less than $10,000, 50 had incomes between $10,000 and $25,000, and 25 had incomes greater than $25,000.

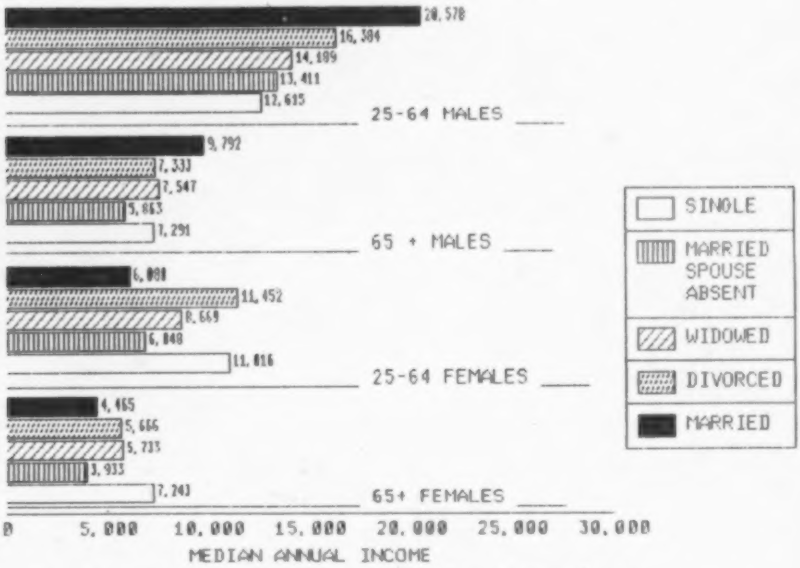
The difference in the income level of black families and white families was considerable. The income of elderly black families in 1982 was about 57 percent of that of elderly white families. The relative differences were even greater when the family was maintained by a woman with no husband present.

While elderly married couples had economic resources approaching those of their sons and daughters, the picture is much different for the divorced, widowed, and others not living in families (chart 15).

There were 8.4 million elderly "unrelated individuals" in 1982, most of whom lived alone and some of whom lived with persons other than their relatives. Elderly unrelated individuals had a 1982 median income of $6,424, which was less than 66 percent that of unrelated individuals of all ages, a relative position that was also true in 1950. Single women were the most likely to have the lowest incomes and to be poor. Thirty-four percent of elderly female unrelated individuals have incomes below $5,000, compared to 25 percent of elderly male unrelated individuals.

Chart 15

MEDIAN ANNUAL INCOMES
BY MARITAL STATUS AND AGE: 1982



SOURCE: U.S. Bureau of the Census, Current Population Survey, March 1983, unpublished data

## 4. The After-Tax Incomes of the Elderly Are Relatively Low

The impact of taxes on the incomes of all age groups is an unknown variable, although in 1980 the U.S. Bureau of the Census estimated the effect of this difference in tax treatment on income by employing a simulation model of Federal, State, payroll, and property tax treatment. Because persons over the age of 65 have relatively low before-tax incomes and because social security benefits are presently not taxed, the elderly tend to pay less in taxes than younger persons. Based on Census simulations, the median after-tax income of households in which the head was 65 years or older was only about 67 percent of the median after-tax income for all households.[13]

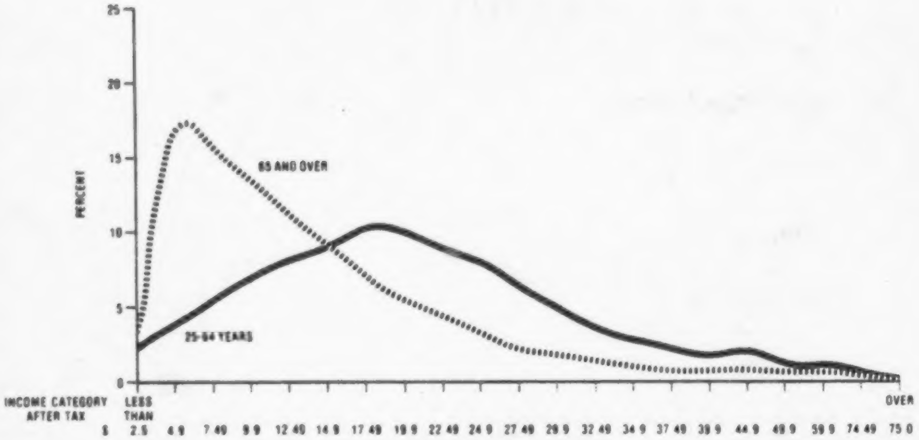
Chart 16 graphically depicts the Census Bureau's after-tax income simulation for members of households headed by persons in two age groups, 25 to 64 years, and 65 years or older. This chart portrays the distribution of members of households by their total household income, which should not be confused with per person income. Based on estimates of the after-tax income of households, members of elderly households remain clustered at the low end of the income distribution, with significantly smaller numbers of elderly persons in households in the middle and high income ranges than persons aged 25 to 64.

---

[13] U.S. Dept. of Commerce. Bureau of the Census. Estimating after-tax money income distributions using data from the March Current Population Survey. P-23, No. 126, August 1983.

Chart 16

### AFTER TAX SIMULATION OF INCOME DISTRIBUTION FOR MEMBERS OF HOUSEHOLDS
### PERSONS 25 TO 64 AND 65 AND OVER
### 1980



SOURCE: U.S. Bureau of the Census, estimating after-tax money income distributions using data from the March Current Population Survey, P-23, August 1983

A number of economists (Sheldon Danziger, Jacques van der Gaag, Eugene Smolensky, and Michael Taussig) have written extensively on income distribution in general, and on the relative economic status of the elderly in particular. They argue that economic well-being is more closely tied to consumption than income. They suggest that traditional census data may understate the economic status of the aged because, at any given level of family money income, the elderly on average: pay less in taxes, own more assets, live in smaller households, and receive more in-kind benefits. It is also clear that the elderly's expenses are higher in some areas such as health care and home maintenance. These factors must all be addressed to draw a more realistic picture of the economic status of the elderly.

## 5. Social Security Benefits Play a Vital Role in the Incomes of the Elderly

Social security benefits are the single largest source of money income for the elderly and the single source on which the largest proportion is most dependent. Social security benefits reach 92 percent of the elderly population and over 50 percent of the elderly depend on these benefits for more than half of their income. Twenty percent of the total elderly population and 40 percent of blacks living alone received virtually all (90 percent or more) of their income from social security.

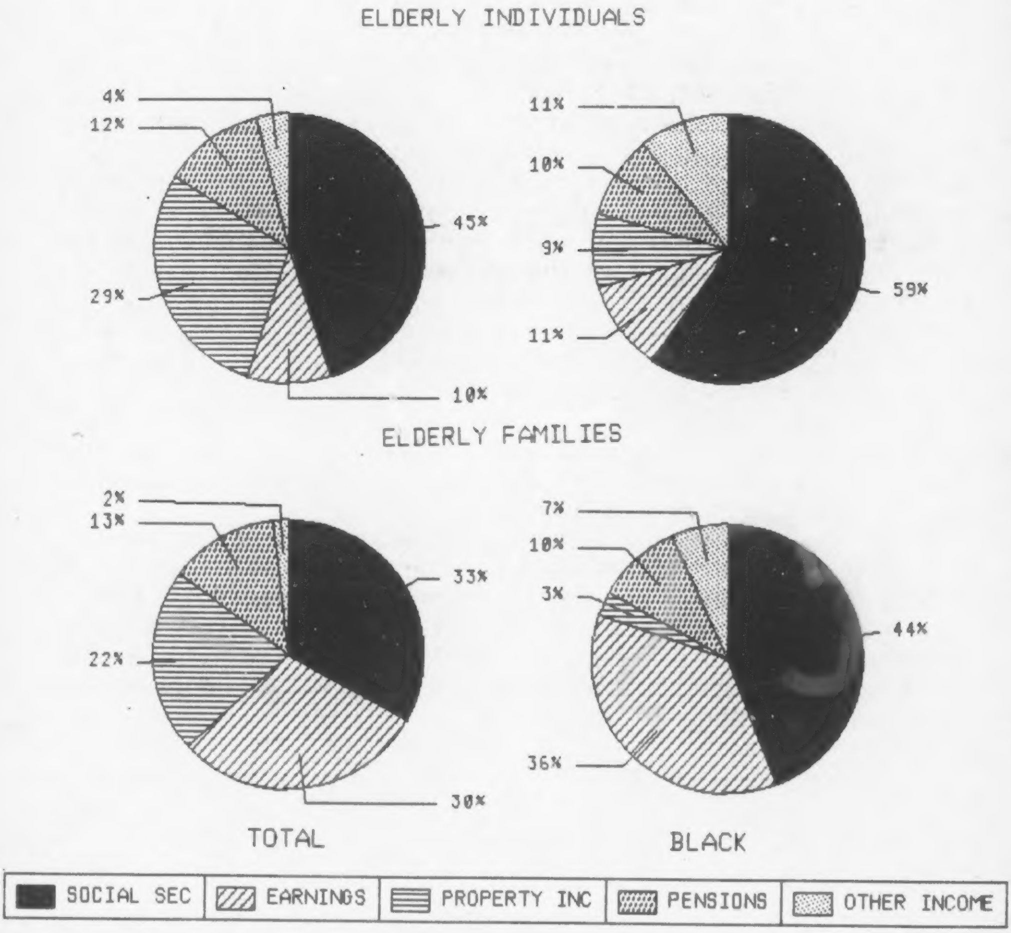
While social security accounted for 33 percent of the total money income of elderly families in 1982, earnings accounted for 30 percent, property income (mainly rents, dividends, and interest) for 22 percent, and private and public pensions for 13 percent. A recent study by the Social Security Administration showed that one of the most significant changes in the source of income for the elderly since the 1960's was a decline in the importance of earnings and increased reliance on retirement income from social security, public and private pensions, and assets. Social security income also increases in relative importance as a person ages.

Wages and earnings contribute far less to the incomes of elderly unrelated individuals than to elderly persons in families, enhancing the predominate role of social security in providing adequate income to elderly persons living alone.

Social security is particularly important as a source of income to elderly blacks (chart 17). While 33 percent of money income to all elderly families was from social security in 1982, it provided 44 percent of money income to elderly black householders. And, while it provided 45 percent of money income to all elderly unrelated individuals, it was responsible for 59 percent of money income to elderly blacks living alone.

Chart 17

SOURCE OF MONEY INCOME IN 1982 FOR ELDERLY UNRELATED INDIVIDUALS AND FAMILIES TOTAL AND BLACK POPULATION



SOURCE: U.S. Bureau of the Census, Current Population Survey, March, 1983

Earnings, property income, and pensions are less universal than is social security and are of varying significance. For example, in 1982, all elderly families receiving property income averaged almost $6,000 from that source and those receiving pensions on average received $6,300 from that source. But black families averaged $1,000 and $5,500, respectively, from those sources. While more elderly receive private pensions than in the past, only 2 percent of the elderly in 1982 relied on pensions for at least 50 percent of their total income.

The economic position of older persons is significantly affected by their labor force status. Those who are year-round full-time workers have incomes close to those of younger people until the age of 70, at which age the median income drops from $19,000 to $16,000. In 1982, there were about 8.5 million persons 55 to 64 years old who worked full time and year round (39 percent of all persons this age); about 350,000 (10 percent) who were 65 to 69 years old; and about 430,000 (3 percent) who were 70 years and over.

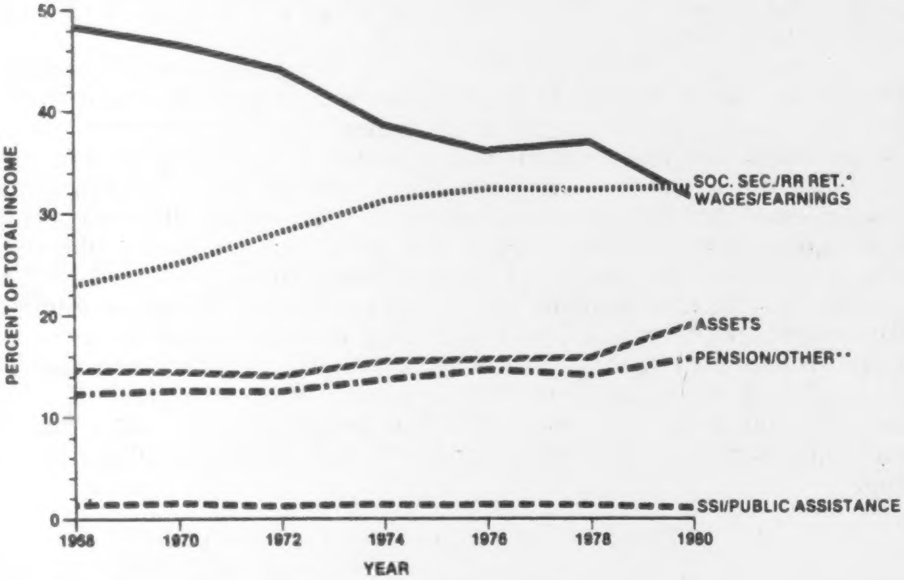
The likelihood of continuing to work after one becomes eligible for retirement is related to the ability to make more from work than from social security or pension benefits. Half of the elderly who worked year round and full time had incomes between $12,500 and $30,000. It is also likely that the health of those with higher earnings is good, which allows them to make a choice about working.

## 6. The Role of Social Security Has Increased

The increasing importance of social security income is evident when compared to the relative contributions of other sources of income for both families and unrelated individuals (charts 18 and 19). This change is in part due to benefit increases in social security enacted during the 1970's and the fact that social security payments are tied to increases in the cost of living, keeping pace with inflation at a better rate than wages and earnings.

## Chart 18

**TRENDS IN SOURCE OF INCOME OF FAMILIES WITH HEAD**
**65 YEARS OR OLDER**
**1968–1980**



*Social Security/Railroad Retirement
**Includes Veterans, Unemployment, Workers Compensation, Annuities, Alimony

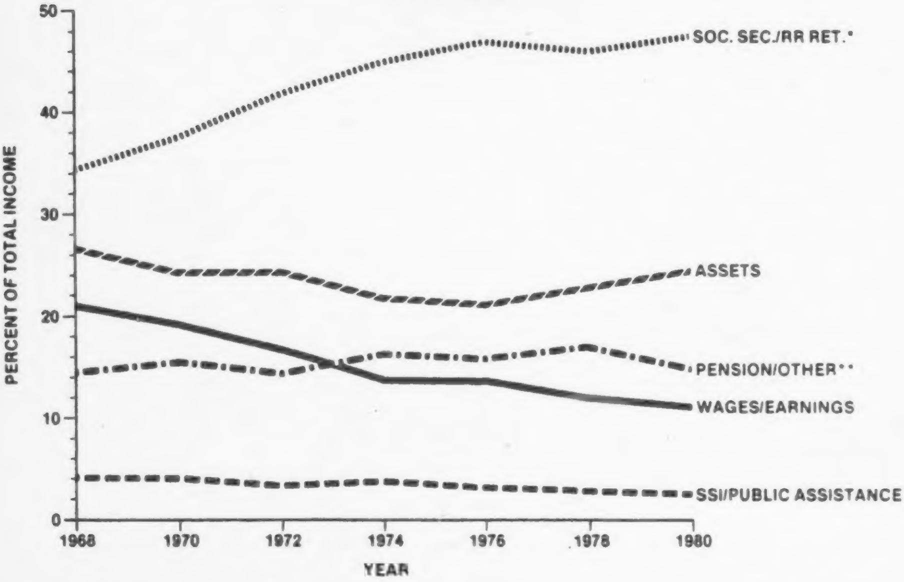
SOURCE U.S. Bureau of the Census, Current Population Surveys, unpublished.
Prepared by Mary Pilato, Congressional Research Service.

The portion of income provided from sources other than social security and wages has remained relatively constant since 1968. However, for unrelated individuals, income from supplemental security income and public assistance declined considerably from 4.1 percent in 1968 to 2.5 percent in 1980.

Families with a head 65 years or older have traditionally relied on wages and earnings for the greater portion of their incomes, although that portion of income contributed by wages steadily diminished over the 1968 to 1980 period to the point where social security is presently of at least equal significance. This is in part due to the decline in labor force participation rates and the trend toward earlier retirement of elderly men.

Chart 19

### TRENDS IN SOURCE OF INCOME OF UNRELATED INDIVIDUALS 65 YEARS OR OLDER 1968-1980



*Social Security/Railroad Retirement
**Includes Veterans, Unemployment, Workers Compensation, Annuities, Allimony

SOURCE: U.S. Bureau of the Census, Current Population Surveys, unpublished.
Prepared by Mary Pilote, Congressional Research Service.

## 7. One Out of Seven Elderly Are Poor and Almost a Quarter Are "Near Poor"

Many persons face poverty for the first time after retirement. One out of seven elderly persons (14.6 percent or 3.8 million) lived in poverty in 1982. This figure does not represent a statistically significant year-to-year improvement from last year's 15.3 percent rate. This rate is a significant improvement, however, from 1970, when one out of four elderly persons lived in poverty, and from 1959, when more than one in three had incomes below the poverty level (table 7). In 1982, for the first time there was no difference in the poverty rates for all persons and for persons 65 and over. However, while the elderly were not more likely to be poor, they were more likely to be near poor. A higher proportion of elderly persons than of younger persons fell below 125 percent of poverty level (23.7 percent for persons over the age of 65 as compared to 19.8 percent of persons under age 65) (table 8).

### TABLE 7.—PERCENT OF PERSONS IN POVERTY BY MAJOR AGE GROUP: 1959–82

| | 1959 | 1970 | 1980 | 1981 | 1982 |
|---|---|---|---|---|---|
| Persons under 65 years | 20.9 | 11.3 | 12.7 | 13.9 | 15.1 |
| Persons 65 years and over | 35.2 | 24.6 | 15.7 | 15.3 | 14.6 |
| In families | 26.9 | 14.8 | 8.5 | 8.4 | 8.5 |
| Householder | 29.1 | 16.5 | 9.1 | 9.0 | 9.3 |
| Male | 29.1 | 15.9 | 8.2 | 8.0 | 8.1 |
| Female | 28.8 | 20.1 | 15.2 | 16.0 | 15.5 |
| Other family members | 24.6 | 13.0 | [1] 7.8 | 7.6 | 7.5 |
| Unrelated individuals | 61.9 | 47.2 | 30.6 | 29.8 | 27.1 |
| Male | 59.0 | 38.9 | 24.4 | 23.5 | 21.2 |
| Female | 63.3 | 49.8 | 32.3 | 31.4 | 28.7 |
| White | 33.1 | 22.6 | 13.6 | 13.1 | 12.4 |
| Black | 62.5 | 47.7 | 38.1 | 39.0 | 38.2 |
| Hispanic | ([2]) | ([2]) | 30.8 | 25.7 | 26.6 |
| Metropolitan | 26.9 | 20.0 | 12.9 | 12.6 | 12.6 |
| Nonmetropolitan | 47.0 | 31.5 | 20.5 | 19.9 | 18.0 |

[1] Other family members with married couples only: The 1980 figure for other family members without married couples was 6.7 percent.
[2] Not available.

Source: U.S. Dept. of Commerce. Bureau of the Census. Current Population Reports. Series P–60, No. 140, and unpublished data.

### TABLE 8.—PERSONS BELOW 125 PERCENT OF POVERTY LEVEL BY AGE, FAMILY STATUS, AND RACE: 1982

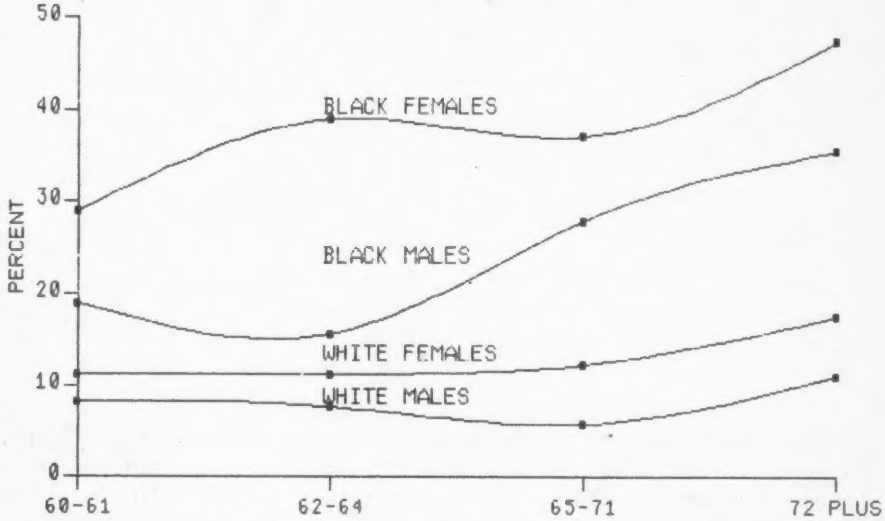
[Number in thousands]

| | Total persons, all ages | | 65 years and older | |
|---|---|---|---|---|
| | Number below 125 percent of poverty level | Percent | Number below 125 percent of poverty level | Percent |
| All races | 46,520 | 20.3 | 6,106 | 23.7 |
| White | 33,071 | 16.9 | 4,889 | 21.0 |
| Black | 11,911 | 43.8 | 1,095 | 51.6 |
| Spanish origin | 5,542 | 38.5 | 244 | 40.9 |
| Persons in families with female householder, no husband present: | | | | |
| All races | 20,289 | 44.9 | 3,475 | 40.6 |
| White | 12,338 | 37.7 | 2,852 | 37.5 |
| Black | 7,469 | 65.6 | 580 | 65.1 |
| Spanish origin | 2,144 | 66.6 | 118 | 69.0 |

Poverty rates increase sharply with age, partly because of substantial reductions in income as a result of retirement and widowhood. The problem is exacerbated by the likelihood of major expenditures for health care. The poverty rate for those aged 60 and 61 years was about 10 percent in 1981, but jumped to nearly 18 percent for those aged 72 years and over.[14]

Chart 20

POVERTY RATE IN 1982
OF PERSONS 60 YEARS AND OVER BY AGE, RACE AND SEX



SOURCE: U.S. Bureau of the Census, 1982 Current Population Survey, unpublished

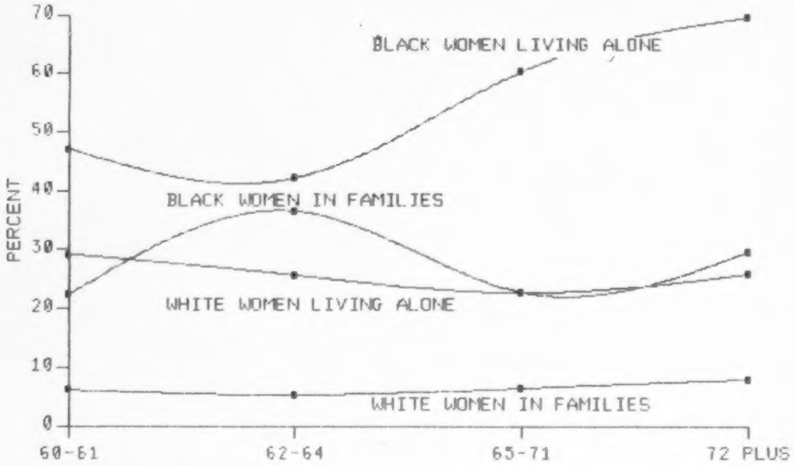
Poverty is also disproportionately high among elderly women and blacks. Elderly white men had a poverty rate of 8.3 percent in 1982, but elderly white women were twice as likely as their male counterparts to be in poverty, black men four times as likely, and black women five times as likely (charts 20 and 21).

---

[14] U.S. Dept. of Commerce. Bureau of the Census. Money Income and Poverty Status of Families and Persons in the United States: 1981, Current Population Reports. Series P-60, No. 134, July 1982, table 15. p. 22.

Chart 21

POVERTY RATE IN 1982
OF WOMEN 60 YEARS AND OVER BY LIVING ARRANGEMENTS AND RACE



SOURCE: U.S. Bureau of the Census, 1982 Current Population Survey, unpublished

Of all poor persons 60 years and over, just over half lived in metropolitan areas and the remainder lived in small towns and rural areas (nonmetropolitan). The poverty rate in 1981 (the latest data available) for those who lived in metropolitan areas was 11.5 percent. But for those who lived in the small towns outside of metropolitan areas and in rural areas, the poverty rate was 18.6 percent, and for aged black women in those areas, it was over 60 percent.

The incidence of poverty is closely associated with the type of income a person has. The lowest poverty rates were reported for older persons who had wage and salary income (4 percent), while over 30 percent of those who had only social security income were poor in 1981.

Of the 5 million persons 55 years old and over who were poor in 1981, less than 500,000 worked and only about 25 percent of those worked full time and year round. Those who worked all year had poverty rates about 50 percent the rate of those who worked part of the year, and about 25 percent of those who did not work at all during the year. Of those poor who worked only part of the year, over 25 percent said they did not work a full year because they were ill or disabled, and about one in seven said they could not find work. Of those poor who did not work at all during the year, 33 percent said they could not work because they were ill or disabled and 40 percent said they were retired.

Poverty levels vary widely by State, as do the relative poverty levels for the elderly as compared with the young population.

According to the 1980 census, the poverty rates for the elderly in most States in 1979 were slightly higher than the poverty rate for all persons. The exceptions included New York, Arizona, California, and Florida. In the latter three "Sun Belt" States, the lower poverty rates for persons 65 years old and over may be related to the presence of substantial numbers of relatively well-to-do retirees who have migrated from other States. The highest 1979 poverty rates for the aged were found in Mississippi (34.3 percent), Alabama (28.4 percent), and Arkansas (28.2 percent); the States with the lowest rates were California, Connecticut, and Wisconsin (8.3, 8.8, and 9.6 percent, respectively).

### 8. Small Number of Poor Elderly Receive Cash Benefits

Although over 15 percent of elderly persons had an income below the poverty level in 1982, only about 33 percent of them received cash income from public assistance. For about 33 percent of such recipients (or 1 in 27 persons over 65), public assistance provided more than half of their income.[15]

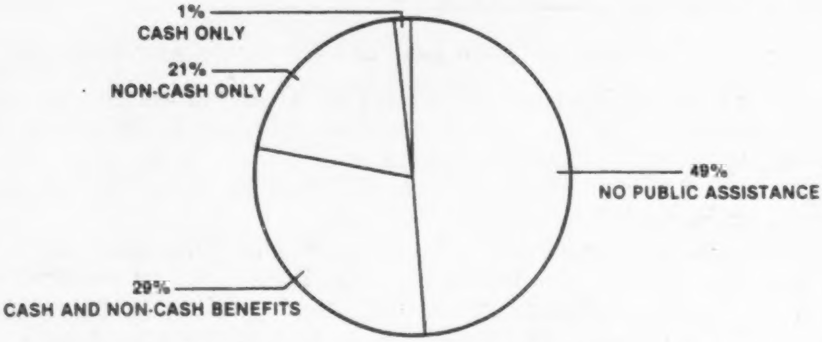
In-kind public transfers in the form of food (food stamps), housing (publicly owned or subsidized rental housing), and medical care (medicare and medicaid), have expanded markedly in the last decade. The current Government definition of poverty, however, is based on money income only and does not include the value of in-kind transfers as income. Among households headed by persons 65 and over which were in poverty in 1981, 50 percent received some form of noncash assistance (chart 22). If the value of in-kind food, housing, and medical care transfers received by the low-income elderly population were regarded as money income, the poverty rate would change.

---

[15] U.S. Dept. of Health and Human Services. Social Security Administration. Office of Policy. Office of Research and Statistics. Income and Resources of the Aged, 1978, Social Security Publication, No. 13-11727, October 1981.

Chart 22

### DISTRIBUTION OF CASH AND NON-CASH PUBLIC ASSISTANCE AMONG HOUSEHOLDERS 65 YEARS AND OLDER AND WITH INCOME BELOW THE POVERTY LEVEL



SOURCE: U.S. Bureau of the Census, unpublished, reported in U.S. Senate Special Committee on Aging, Developments in Aging: 1982.

A recent study determined that the various methods used to value in-kind benefits resulted in a large range of poverty rates depending on the methodology used and the type of benefits included.[16] Estimating the value of noncash benefits is difficult and controversial. Considering money income only, the poverty rate for elderly persons in 1979 was 14.7 percent. Using market values, if food and housing benefits were included, the poverty rate would have been reduced—but only to 12.9 percent. Adding the market value of medical benefits, including institutional care, reduced the poverty rate significantly but there is serious disagreement over the inclusion of medical care—especially institutional care—for determining poverty status.

Except for medicare, most of the noncash benefits received by elderly households were means-tested; i.e., income criteria determined eligibility. Of the 1.1 million elderly households that received food stamps in 1981, 86 percent had incomes below 125 percent of the poverty level and received food stamps with a mean face value of less than $500 annually. About 949,000 (5 percent) elderly households lived in Government subsidized housing. About 2.5 million (14 percent) elderly households received medicaid benefits, and, in 16.8 million elderly households, medicare covered at least one person. Elderly households made up approximately 17 percent of households receiving food stamps, about 33 percent of the households in public or otherwise subsidized housing, and 30 percent of those who received medicaid.[17]

---

[16] U.S. Dept. of Commerce. U.S. Bureau of the Census. Technical Paper No. 50, Alternative Methods for Valuing Selected In-Kind Transfer Benefits and Measuring Their Effect on Poverty. Washington, U.S. Govt. Print. Off., 1982.

[17] U.S. Dept. of Commerce. Bureau of the Census. Characteristics of Households Receiving Selected Noncash Benefits: 1981 (Advance Data from the March 1982 Current Population Survey), Current Population Report. Series P-60, No. 135. Washington, U.S. Govt. Print. Off., 1982, tables B, C, and I.

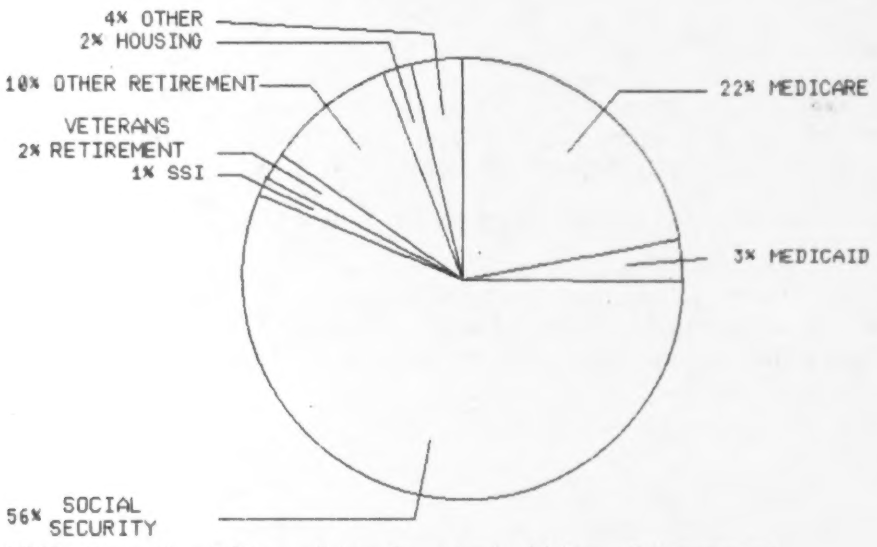
## 9. Large Numbers of Elderly Remain Poor Despite Significant Federal Outlays

The persistence of relatively high rates of poverty among the elderly, despite the enormous sums devoted in the Federal budget for elderly program recipients ($218 billion in 1983), presents a paradox. There are three plausible explanations for this situation.

First, a large portion of elderly persons with incomes below the poverty line do not participate in the means-tested programs designed to assist them. In fact, nearly half (49 percent) of elderly households in the poverty category received neither cash nor in-kind assistance from means-tested programs.

Chart 23

FEDERAL OUTLAYS BENEFITING THE ELDERLY
FISCAL YEAR 1983



SOURCE: Executive Office of the President, Office of Management and Budget

Second, of the approximately $218 billion spent for the elderly, the overwhelming portion is committed to social insurance programs (chart 23). These certainly aid many low-income elderly persons, but they are not, by definition, programs targeted at the poverty population. Instead, the social insurance programs are earned entitlements which make benefits available to all those who qualify on the basis of age and other factors. An analysis of fiscal year 1983 Federal budget expenditures reveals that 92 percent of the total spent on elderly persons was allocated to retirement and health insurance programs that are largely self-funded through lifetime contributions from individuals and employers. About $17 billion, or 2.1 percent of the entire budget, was spent to assist low-income elderly persons through cash or in-kind means-tested programs.

The third reason that elderly poverty persists despite the current level of Federal spending is that maximum benefits in the principal means-tested programs, such as supplemental security income, are below the poverty level.

## C. HEALTH STATUS

Contrary to stereotype, the older population as a whole is healthier than is commonly assumed. The majority of older Americans—even those with physical limitations—assess their health favorably. In 1981, 80 percent of elderly persons described their own health as good or excellent compared with others of their own age; only 8 percent said their health was comparably poor.[18] About 40 percent of the elderly population reported that, for health reasons, a major activity had been limited (compared with about 20 percent of the population 45 to 64 years), but 54 percent reported no limitations of any kind in their activities.[19] Not until age 85 and over do about 50 percent of the population report being limited or unable to carry on a major activity because of a chronic illness.[20]

### 1. Adequate Income and Ability To Work Means Better Health

Good health is associated with higher incomes (chart 24). More than 40 percent of those with incomes over $25,000 described their health as excellent compared with others of their own age, but less than a quarter of those with low income (less than $7,000) reported excellent health.[21]

---

[18] U.S. Dept. of Health and Human Services. Public Health Service. National Center for Health Statistics. 1980 Health Interview Survey, publication forthcoming.

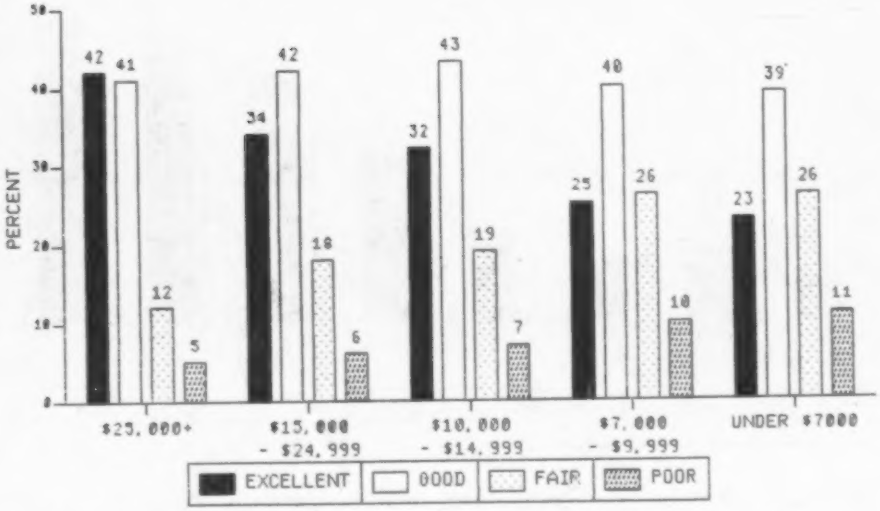
[19] U.S. Dept. of Health and Human Services. Public Health Service. National Center for Health Statistics. Current Estimates from the National Health Interview Survey, United States, 1981, Vital and Health Statistics. Series 10, No. 141, DHHS Publication No. (PHS) 83-1569. Washington, U.S. Govt. Print. Off., October 1982, table 14, p. 24.

[20] U.S. Dept. of Health and Human Services. Federal Council on Aging. The Need for Long Term Care: Information and Issues. DHHS Publication No. (OHDS) 81-20704. Washington, U.S. Govt. Print. Off. pp. 27-29.

[21] U.S. Dept. of Health and Human Services. Public Health Service. National Center for Health Statistics, publication forthcoming, Ibid.

Chart 24

SELF-ASSESSMENT OF HEALTH BY INCOME RANGE
PERSONS 65 YEARS AND OLDER
1981



Source: U.S. Bureau of the Census. Current Population Surveys. 1981 and 1983

Persons 65 years and over have about twice as many days of restricted activity due to illness as the general population (almost 40 days versus 19 in 1981). But those elderly who worked do not experience a marked difference in the number of lost workdays—about 4 or 5 days a year on the average for both the younger and older working population.[22]

## 2. Greatest Need for Assistance Is Among the Very Old

The very old do have more need for personal assistance than the younger-old. For instance, in 1978, less than 1 percent of the noninstitutional population 65 to 84 years needed help in eating while about 4 percent of the population 85 and over did (chart 25); about 10 percent of the very old needed help toileting versus less than 2 percent of the younger-old; 11 percent of the 85 and over group needed help dressing, and 18 percent needed help bathing, while the figures were about 3 and 4 percent respectively for the 65- to 84-year-old group. Based on these functional measures, more than 80 percent of the noninstitutionalized very old were able to take care of their own daily needs.[23]

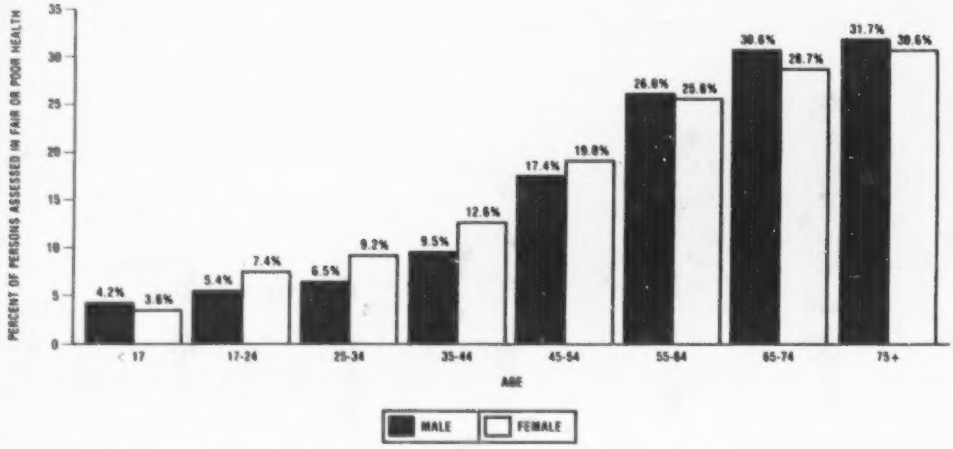
---

[22] U.S. Dept. of Health and Human Services. Public Health Service. National Center for Health Statistics. Current Estimates from the National Health Interview Survey, United States, 1981. Ibid., table 12, p. 22.

[23] U.S. Dept of Health and Human Services. Federal Council on Aging. Ibid., pp. 27–29.

Chart 25

PERSONAL HEALTH CARE ASSESSMENT BY SEX AND AGE—1981



SOURCE: National Center for Health Statistics, 1981 Health Interview Survey, unpublished.

Friends, spouses, relatives, and others provide valuable assistance to many elderly persons who live in the community. A little over 60 percent of persons 85 years and older who live with nonrelatives need assistance in daily living. This figure is 48.7 percent for those who live with relatives other than a spouse and 31.9 percent for the extreme aged who live with a spouse. Almost 33 percent of this age group who live alone are in need of assistance.

### 3. OUT-OF-POCKET HEALTH EXPENSES FOR THE ELDERLY ARE ACTUALLY HIGHER NOW THAN THEY WERE PREVIOUS TO THE ENACTMENT OF MEDICARE AND MEDICAID

Health expenditures by elderly persons continue to climb faster than increases in either income or the overall inflation rate, even though their health status remains relatively stable.

Health care expenditures for the elderly not covered by medicare now equal an estimated average of 13.6 percent of their income.[24]

### 4. CHRONIC CONDITIONS, ALTHOUGH NOT NECESSARILY LIMITING, ARE THE BURDEN OF OLDER AGE

The pattern of chronic morbidity has changed in the past 80 years. Whereas acute conditions were predominant at the turn of the century, chronic conditions are now the most prevalent health problem for elderly persons. There has also been a change in the pattern of illness within an individual's lifetime. That is, as people age, acute conditions become less frequent and chronic ones more prevalent. The likelihood of having a chronic illness or disabling condition increases dramatically with age. Over 80 percent of persons 65 and over have at least one chronic condition and multiple conditions are commonplace in the elderly.

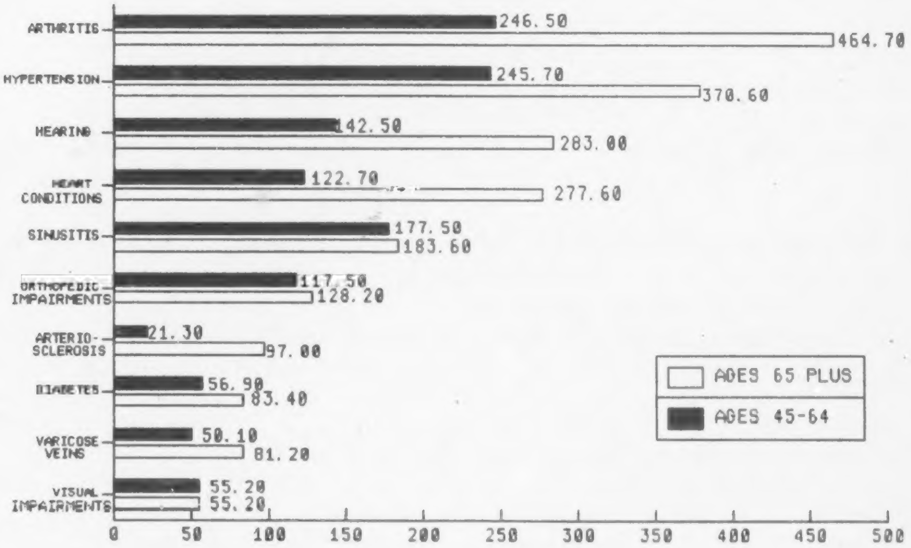
---

[24] U.S. Congress. Senate. Health Care Expenditures for the Elderly. Prepared by the Staff of the Senate Special Committee on Aging. Washington, U.S. Govt. Print. Off., 1984, in production.

Even though there has been significant improvement in death rates, measures from the health interview surveys from 1965 (the first year of the survey) through 1979, do not show any major improvements in the health status of the elderly. In the early part of this century, infectious and parasitic diseases were the major causes of illness among the elderly. Now, however, the major causes are chronic diseases, accidents (especially traffic accidents), and stress-related conditions.[25] The leading chronic conditions causing limitation of activity for the elderly in 1981 were arthritis and hypertensive disease, hearing impairments, and heart conditions (chart 26). Stress-related conditions include hypertension, attempted suicides, drug dependency, and so forth. The principal diagnoses made by doctors for the elderly in the 1980–81 period were hypertension, diabetes, chronic ischemic heart disease, cataracts, and osteoarthritis.[26]

Chart 26

MORBIDITY FROM TOP TEN CHRONIC CONDITIONS-RATES PER 1,000 PERSONS
1981



Source: National Center for Health Statistics, 1981 HIS Survey

Many elderly people are hospitalized for chronic conditions rather than illnesses leading to death. Digestive conditions, genitourinary conditions, and injuries are leading causes of hospitaliza-

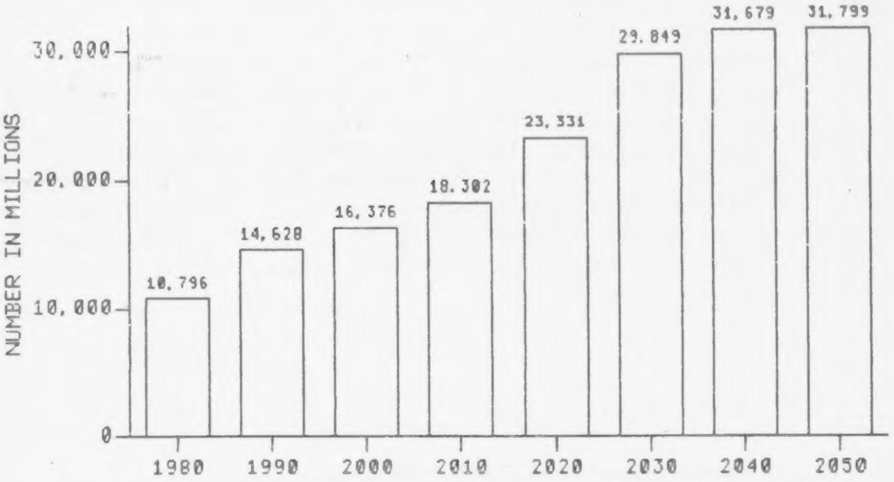
---

[25] Omran, Abdel R. Epidemiological Transition in the United States: The Health Factor in Population Change. Population Bulletin, v. 32, No. 2, May 1977. Washington, Population Reference Bureau, Inc.

[26] U.S. Dept. of Health and Human Services. Public Health Service. National Center for Health Statistics. Unpublished.

Chart 27

NUMBER AND DISTRIBUTION OF PERSONS WITH LIMITATION OF ACTIVITY DUE TO CHRONIC CONDITION ACTUAL AND PROJECTED



Source: Based on the 1980 Health Interview Survey, National Center for Health Statistics and U.S. Bureau of the Census, Projections of the Population of the United States: 1982 to 2050, Current Reports, Series P-25, No. 922. Middle series projections.

Note: Projections are based on current rates of limitation of activity due to chronic illness and U.S. Bureau of the Census population projections without making assumptions about future changes in rates for limitation of daily activity due to chronic illness in the population.

tions among the elderly.[27] Most visits to physicians by older persons are for chronic conditions such as circulatory problems, diabetes, arthritis, and eye conditions.

There are differences in the types of conditions experienced by people of different sex or race. The diseases which affect elderly men tend to be acute and predominate as causes of death while those which affect elderly women tend to be chronic and predominate as causes of illness. The health situation of elderly blacks is generally poorer than that of elderly whites. For example, hypertension was more prevalent among blacks 65 to 74 years old (45 percent) than whites (33 percent) in the 1971–75 period.[28]

Severe effects of chronic illness may prevent individuals from functioning independently and have an impact on the need for future health and long-term care services. In 1980, 10.8 million people over the age of 65 had some degree of limitation in daily activity, from mild to severe, due to chronic illness (chart 27). Future estimates are that 16.4 million persons 65 years or older are expected to have functional limitations at the turn of the century. This figure will reach 23.3 million by the year 2020 and 31.8 million by 2050.

---

[27] U.S. Dept. of Health and Human Services. Public Health Service. National Center for Health Statistics. 1981 Health Interview Survey. Unpublished.

[28] U.S. Dept. of Health and Human Services. Public Health Service. National Center for Health Statistics. Limitations of Activity Due to Chronic Conditions. Ibid.

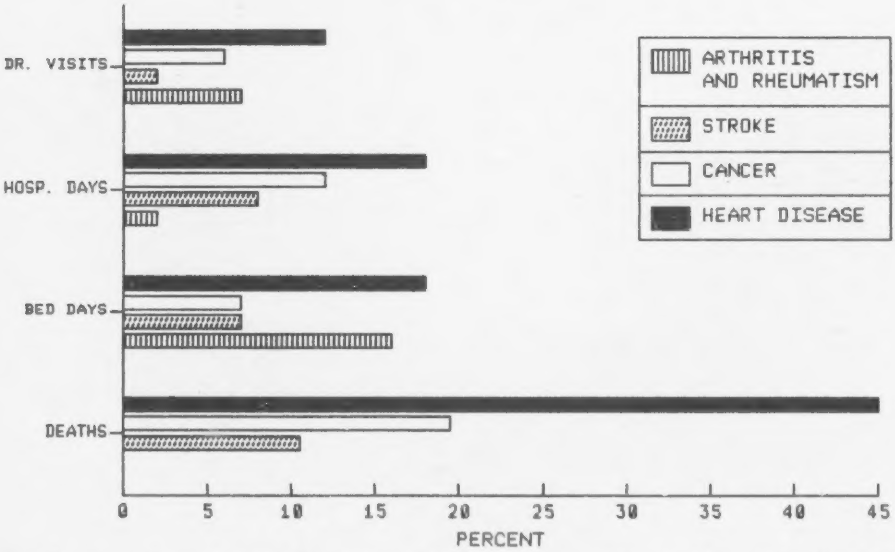
These projections demonstrate that, simply as a result of the aging of the population, twice as many people may need health and long-term care services as presently do.

## 5. HEART DISEASE IS THE LEADING HEALTH PROBLEM FOR THE ELDERLY

Heart disease leads all other conditions in each of four major indicators of mortality or health care utilization accounting for 10 percent of all doctors visits, 18 percent of all short-stay hospital and bed disability days, and 45 percent of all deaths (chart 28). As described earlier, heart disease, cancer, and stroke account for over three-quarters of all deaths among the elderly. They also are responsible for about 20 percent of doctor visits, 40 percent of hospital days and 50 percent of all days spent in bed. Arthritis and rheumatism, the leading chronic conditions, on the other hand, account for relatively few deaths and only 2 percent of hospital days. However, they account for 16 percent of days spent in bed, nearly as much as for heart disease.[29]

Chart 28

BURDEN OF ILLNESS ACCORDING TO SELECTED CONDITIONS
PERSONS AGE 65 AND OLDER
1980



Source: Reported in Health : United States: 1982, National Center for Health Statistics

---

[29] U.S. Dept. of Health and Human Services. Public Health Service. National Center for Health Statistics. Division of Health Care Statistics. Division of Health Interview Statistics. Division of Vital Statistics. First printed in Health. United States, 1982. National Census for Health Statistics.

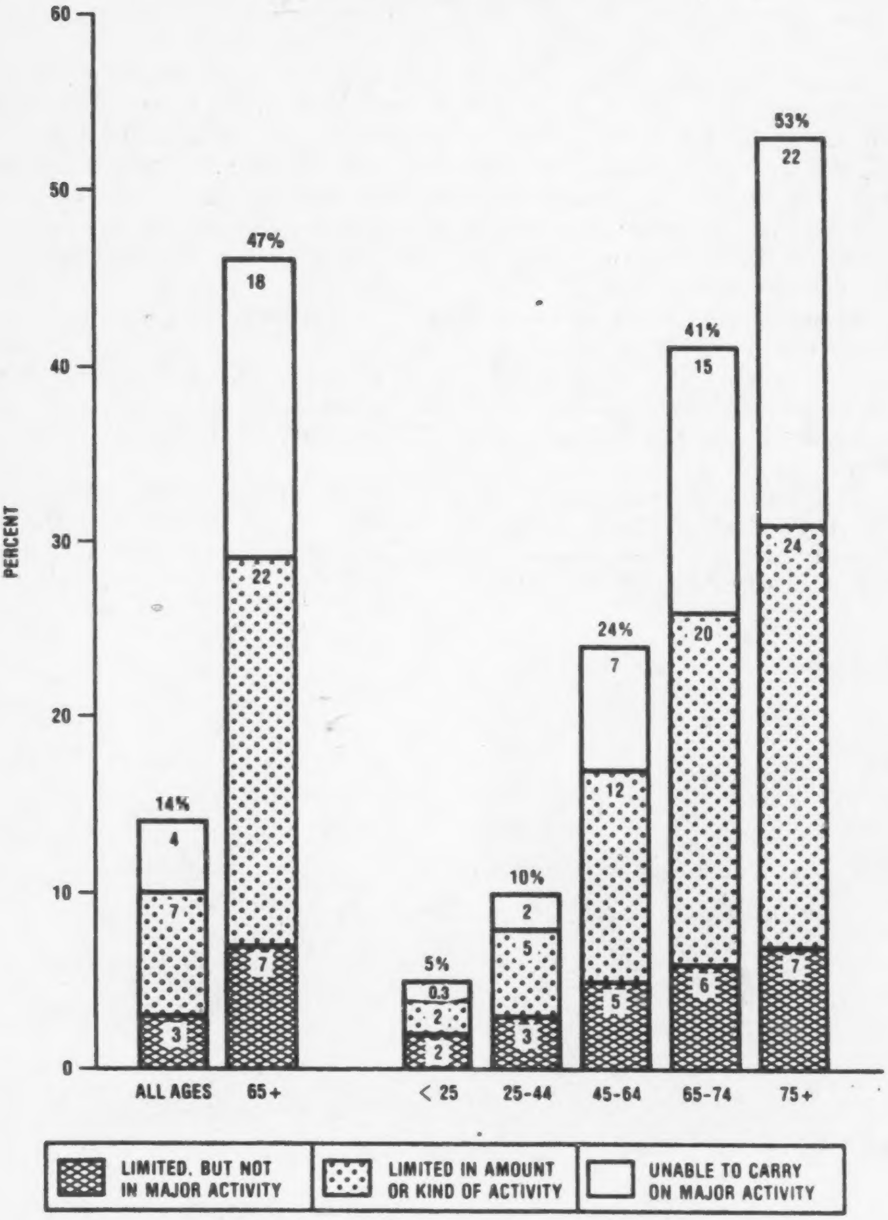
## 6. ACTIVITY LIMITATION DUE TO ILLNESS INCREASES WITH AGE

The severity of any disease can differ tremendously from person to person, causing varying degrees of limitation in activity. For example, one person with arthritis may become housebound, while another only suffers from occasional flareups.

A significantly higher proportion of persons 65 and older than persons under age 65 are limited in activity due to a chronic condition (chart 29). However, it is not until age 75 that over 50 percent of the population are limited and only 22 percent of this age group are limited to the point that they cannot carry on a major activity.

Chart 29

## LIMITATION OF ACTIVITY DUE TO CHRONIC CONDITIONS BY TYPE OF LIMITATIONS AND AGE GROUP—1981



SOURCE: National Center for Health Statistics. 1981 Health Interview Survey, unpublished.

## 7. THE ELDERLY ARE THE HEAVIEST USERS OF HEALTH SERVICES

With a greater prevalence of chronic conditions than in the population at large, older persons use medical personnel and facilities somewhat more frequently than do younger people. Persons 65 and over average six doctor visits for every five made by the general population. The elderly are hospitalized approximately twice as often as the younger population, stay twice as long, and use twice as many prescription drugs.

Since 1965, the year medicare was enacted, elderly persons have increased their use of short-stay hospitals by more than 50 percent versus an 11 percent increase for the total population. The hospital discharge rate (number of discharges per 1,000 population) for the very old is over 75 percent higher than that for the 65- to 74-year-old group. The average hospital stay for persons under age 65 was about 6 days compared with almost 12 days for the 85-year-and-over group.[30]

Hospital services are the largest personal health expenditure, accounting for 44 percent of the total. In 1981, persons age 65 and over, representing 11 percent of the population, used 39.3 percent of short-stay hospital days. The population 75 and over, only 4.4 percent of the population, used 20.7 percent of short-stay hospital days.

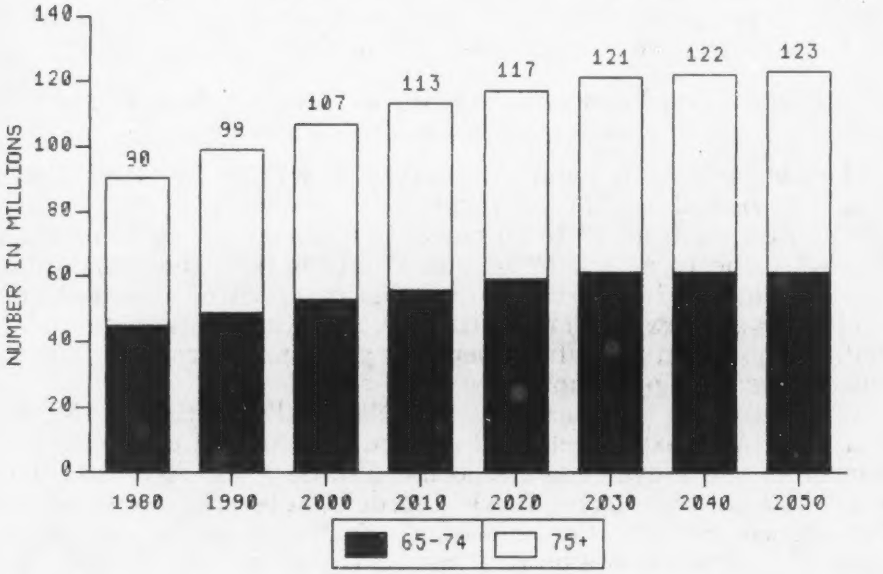
The aging of the population will result in an older hospital patient population and, unless there are major breakthroughs in health care and disease prevention, an increased need for availability of hospital care (chart 30).

---

[30] U.S. Dept. of Health and Human Serivices. Federal Council on Aging. Ibid., pp. 39–41.

Chart 30

NUMBER AND DISTRIBUTION OF SHORT-STAY HOSPITAL DAYS
PERSONS 65 YEARS AND OLDER BY AGE GROUP
ACTUAL AND PROJECTED - 1980-2050



Source: National Center for Health Statistics, Office of Analysis and Epidemiology, and U.S. Bureau of the Census, Series P-25 No. 922 and Series P-25, No. 917

According to forecasts based on current rates of short-stay hospital utilization and U.S. Bureau of the Census population projections, to meet the health requirements of the elderly population, there will be a need to increase hospital services by 42 percent by the turn of the century, by 92 percent by the year 2020, and by 172 percent by the middle of the next decade.

Utilization of physician services increases with age. In 1981, persons aged 45 to 54 averaged 4.7 doctor visits a year, while persons between age 65 and 74 averaged 6.3 visits. And, according to results of the 1981 Health Interview Survey, while 71.8 percent of persons in the 45 to 54 age group reported that they had seen a doctor in the last year, 78.3 percent of persons 65 to 74, and 83.3 percent of persons 75 years or older reported this was the case. Since the enactment of medicare, the average number of physician contacts and the percentage of persons 65 and over reporting that they had seen a physician in the last year has increased significantly, particularly for persons with low incomes.

The disparity between elderly and young populations in the use of physician visits is not as great as the disparity for other forms of health care. In 1980, persons under 65, 88.9 percent of the population, accounted for 84.9 percent of physician visits, while those 65 or over, 11 percent of the population, accounted for 15 percent of visits.

The aging of the population will create a greater demand for physician care. According to projections based on 1980 physician visit rates and U.S. Census Bureau population projections, the need for physician visits will increase by 18 percent (over 30 million visits) by the year 2000, by 30 percent (over 50 million visits) by 2020 and by over 36 percent (over 110 million visits) by 2050.

### 8. PSYCHIATRIC PROBLEMS ARE NOT AS FREQUENT FOR ELDERLY PERSONS AS FOR YOUNGER PERSONS

The elderly are frequently described as having the same prevalence of mental health or psychiatric problems as the general public, ranging from 15 to 20 percent of persons 65 years or older. However, due to a lack of adequate information, this assumption has been inferred from nonage specific data. Three recent studies conducted in New Haven, Baltimore, and St. Louis demonstrate that, for noninstitutionalized persons, psychiatric problems are not constant across age groups.[31]

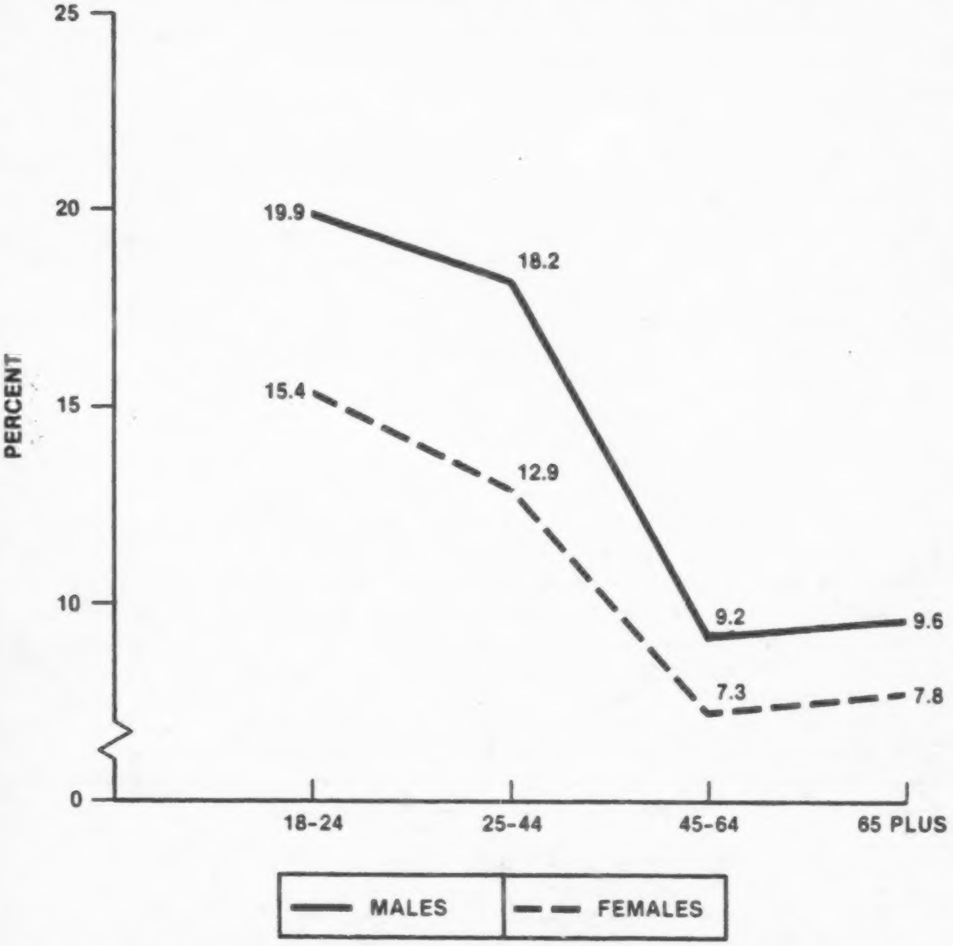
These studies, sponsored by the National Institute of Mental Health (NIMH) examined 9,000 noninstitutionalized participants to determine the prevalence of specific disorders (affective disorders, panic and obsessive/compulsive disorders, substance abuse and/or dependence, somatization disorders, antisocial personality disorders, schizophrenia and phobia) and an eighth related disorder, cognitive impairment. Persons 65 years and older were found to have the lowest overall rates for all age groups when all eight disorders were grouped together (chart 31).

---

[31] Myers, Jerome K. et al. The Prevalence of Psychiatric Disorders In Three Communities: 1980-1982.

Chart 31

## AVERAGE SIX-MONTH PREVALENCE OF PSYCHIATRIC DISORDERS OR SEVERE COGNITIVE IMPAIRMENT BY SEX AND AGE GROUP 1980-1982



NOTE: Includes: affective disorders, panic disorders, obsessive-compulsive disorders, alcohol and drug abuse or dependence, socialization disorders, anti-social personality, servere or mild cognitive impairment, and schizophrenia or schizophrenic form.

SOURCE: Myers, Jerome K. et al., *The Prevalence of Psychiatric Disorders in Three Communities: 1980-82.*

While the elderly have the lowest rates for all psychiatric disorders, some mental health problems, such as substance abuse and affective disorders, become rarities in the upper age ranges. Low rates of mental disorders are in part responsible for the fact that older persons use mental health programs at half the rate of the general population.

These findings do not discount the fact that many elderly suffer severe feelings of grief and depression due to events such as the loss of loved ones, income reduction, and increasing physical limitation. However, these problems may be seen as transitory in nature and not as irreversible disorders.

Tragically, the primary mental health problem of older age is cognitive impairment, with rates for mild impairment being substantially higher than rates for severe impairment. The NIMH studies found that rates for mild cognitive impairment were about 14 percent for both elderly males and females. Rates for severe impairment were 5.6 percent for elderly men and 3 percent for elderly women.

It is currently known that Alzheimer's disease affects more elderly persons than any other disease causing cognitive impairment. As early as 5 years ago, this disease was neglected by both laymen and the medical and scientific communities, and was usually not distinguished from aging in general. However, through extensive research in this and other countries, considerable progress is being made in advancing understanding about this disease.

Failure in cognitive functioning is one of the principal reasons for institutionalization of the elderly. Data from the 1977 Nursing Home Survey, the latest data available, indicates that 22.3 percent of nursing home residents had "primary diagnoses" of a mental disorder or senility with psychosis.

Another indicator of mental health problems, suicide rates, although extremely low when compared to other causes of death, are higher for elderly persons than for other age groups. In 1979 and 1981, the suicide rate was about 19 per 100,000 for persons 65 to 74, about 22 per 100,000 for the 75 to 84 age range, and between 14.6 and 16.3 per 100,000 for persons 85 years and older.[32]

## 9. SMALL NUMBERS OF ELDERLY LIVE IN NURSING HOMES

Only about 5 percent of the elderly population live in nursing homes. In 1982, an estimated 1.3 million elderly persons resided in nursing homes. An estimated 1.5 percent (232,000) of those aged 65 to 74 years old were in a nursing home as compared with about 6 percent (527,000) of those aged 75 to 84 years, and about 23 percent (557,000) of those 85 and over (table 9). The rate of nursing home use by the elderly has almost doubled since the introduction of medicare and medicaid in 1966, from 2.5 to 5 percent of the over-65 population. Almost 75 percent of nursing home residents are without a spouse as compared with just over 40 percent of the noninstitutionalized elderly. Such statistics, along with those which show that nursing home residents tend to have health problems which significantly restrict their ability to care for themselves, suggest that the absence of a spouse or other family member who can provide informal support for health and maintenance requirements is the most critical factor in the institutionalization of an older person.

---

[32] Ibid., pp. 46–47.

It is likely that the nursing home population will continue to grow rapidly, partly because of the rapid growth in the size of the very old population, and partly because of the increasing gap in life expectancy between husbands and wives.[33]

According to projections based on current estimates for the nursing home population and U.S. Census Bureau population projections, by the turn of the century, this number is expected to increase 80 percent to 2.2 million and, over the next 50 years, more than triple to 5.4 million (chart 32).

TABLE 9.—POPULATION 65 YEARS AND OVER IN NURSING HOMES BY AGE

[Numbers in thousands]

| Age | 1963 | 1973 | 1977 | 1982 (estimate)[1] |
|---|---|---|---|---|
| 65 years and over | 448 | 961 | 1,126 | 1,316 |
| 65 to 74 | 93 | 159 | 211 | 232 |
| 75 to 84 | 207 | 394 | 465 | 527 |
| 85 years and over | 148 | 408 | 450 | 557 |

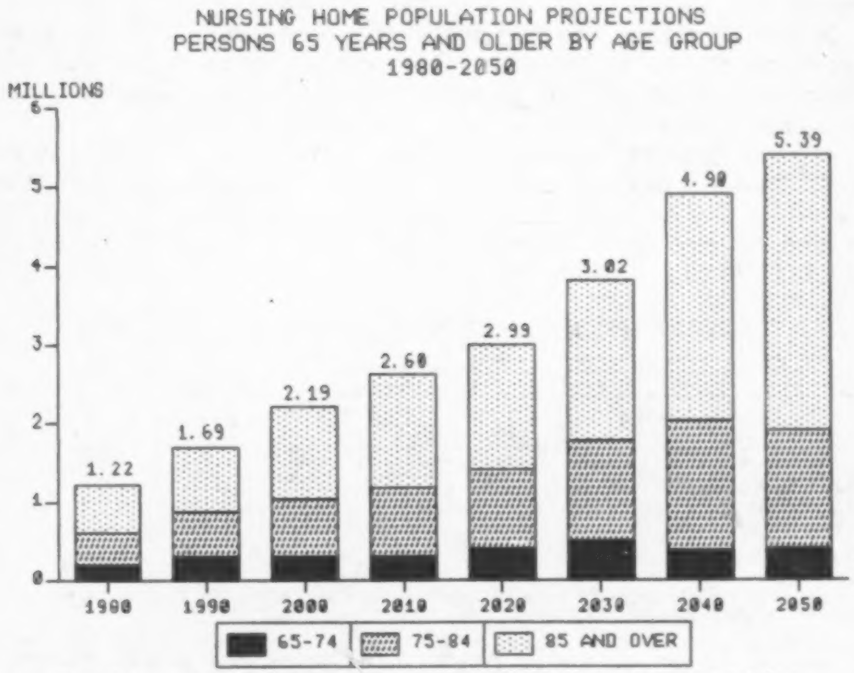
[1] Based on 1982 estimate and proportion of the population for each age group in nursing homes in 1977: 65 plus years, 0.049; 65 to 74 years, 0.0144; 75 to 84 years, 0.064; 85 plus years, 0.2259.

Source: The data for 1963, 1970–74, and 1977 are from the U.S. Dept. of Health and Human Services. Public Health Service. National Center for Health Statistics. Nursing Home Residents: Utilization, Health Status and Care Received, 1977 National Nursing Home Survey, Vital and Health Statistics. Series 13, No. 51, HHS Publication No. (PHS) 81-1712. Washington, U.S. Govt. Print. Off.

---

[33] Ibid., pp. 42–43.

Chart 32



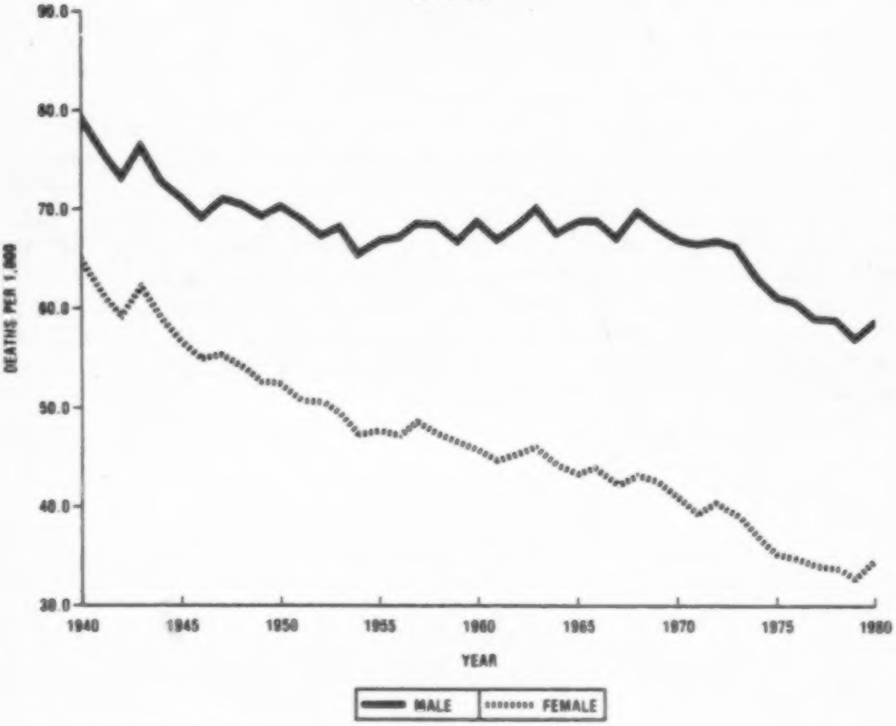
Source: Based on most recent revised estimates of the 1977 population base, U.S. Bureau of the Census, Series P-25, No. 917-1977, estimated, and Series P-25, No. 922, October, 1982. Middles Series Projections; and the National Nursing Home Survey (1977), National Center for Health Statistics

## 10. Death Rates for the Elderly Have Improved Dramatically in the Last Four Decades

As noted earlier, the last four decades have seen tremendous improvement in life expectancy. Some of the change in mortality for elderly persons is obscured by the aging of the elderly population. Analysis of trends in mortality is enhanced by examining age-adjusted death rates which are relatively free from the distortions associated with a changing age composition. The age-adjusted death rate for the elderly decreased by 38 percent—26 percent for males and 48 percent for females—from 1940 to 1980 (chart 33).

## Chart 33

### AGE ADJUSTED MORTALITY RATES FOR POPULATION 65 YEARS AND OLDER 1940-80



SOURCE: National Center for Health Statistics, unpublished tabulations, compiled by Lois Fingerhut

## 11. HEART DISEASE, CANCER, AND STROKE ARE THE LEADING CAUSES OF DEATH FOR THE ELDERLY

As mentioned earlier, in the United States, three out of four elderly persons die from heart disease, cancer, or stroke. Heart disease was the major cause of death in 1950, and remains so today even though there have been rapid declines in death rates from heart diseases since 1968, especially among females. Death rates from cancer have continued to rise since 1900, especially deaths caused by lung cancer. Cancer accounted for about 25 percent of all deaths for those aged 65 to 74 years, a little less than 20 percent of the deaths for the 75- to 84-years-old group, and about 10 percent for the very old.[34] Even if cancer were eliminated as a cause of death, the average lifespan would be extended by only 2 to 3 years (table 10) and more would then die from heart disease. Eliminating deaths due to major cardiovascular-renal diseases would add an average of 11.4 years to life at age 65, and would lead to a sharp increase in the proportion of older persons in the total population.[35] The third leading cause of death among the elderly, stroke, has been a decreasing factor since 1968.

---

[34] U.S. Dept. of Health and Human Services, Public Health Service, National Center for Health Statistics. Unpublished tabulations, compiled by Lois Fingerhoot.

[35] Health: United States, 1981. Ibid., pp. 20–23.

## TABLE 10.—GAIN IN EXPECTATION OF LIFE AT BIRTH DUE TO ELIMINATION OF SPECIFIED CAUSES OF DEATH: 1959–61, 1969–71, 1978

| Cause of death | Total population | | | White male | | | White female | | |
|---|---|---|---|---|---|---|---|---|---|
| | 1959–61 | 1969–71 | 1978 | 1959–61 | 1969–71 | 1978 | 1959–61 | 1969–71 | 1978 |
| 1. Tuberculosis, all forms | 0.10 | 0.04 | 0.02 | 0.10 | 0.03 | 0.02 | 0.05 | 0.02 | 0.01 |
| 2. Infective and parasitic diseases | .22 | .17 | .17 | .20 | .13 | .14 | .14 | .12 | .14 |
| 3. Malignant neoplasms of digestive organs and peritoneum | .66 | .60 | .71 | .63 | .55 | .63 | .68 | .62 | .72 |
| 4. Malignant neoplasms of respiratory system | .32 | .50 | .73 | .49 | .69 | .92 | .11 | .22 | .43 |
| 5. Malignant neoplasms | 2.27 | 2.47 | 3.09 | 2.12 | 2.31 | 2.85 | 2.43 | 2.57 | 3.12 |
| 6. Diabetes mellitus | .22 | .24 | .22 | .15 | .17 | .15 | .27 | .28 | .25 |
| 7. Diseases of the heart | 5.89 | 5.86 | 7.01 | 6.51 | 6.14 | 6.49 | 5.04 | 5.17 | 6.94 |
| 8. Cerebrovascular diseases | — | 1.19 | 1.14 | — | .86 | .74 | — | 1.36 | 1.42 |
| 9. Arteriosclerosis | .18 | .13 | .16 | .15 | .09 | .10 | .21 | .17 | .21 |
| 10. Influenza and pneumonia | .53 | .47 | .39 | .46 | .41 | .33 | .42 | .40 | .39 |
| 11. Bronchitis, emphysema, and asthma | — | .20 | .14 | — | .26 | .17 | — | .10 | .10 |
| 12. Diseases of the respiratory system | — | .83 | .84 | — | .86 | .85 | — | .61 | .71 |
| 13. Peptic ulcer | .09 | .06 | .04 | .11 | .06 | .04 | .05 | .04 | .03 |
| 14. Cirrhosis of liver | .19 | .28 | .27 | .22 | .30 | .29 | .15 | .20 | .18 |
| 15. Nephritis and nephrosis | — | .07 | .06 | — | .05 | .05 | — | .05 | .05 |
| 16. Congenital anomalies | .36 | .29 | .25 | .37 | .30 | .25 | .36 | .30 | .25 |
| 17. Certain diseases of early infancy | 1.12 | .82 | .49 | 1.12 | .82 | .44 | .90 | .66 | .37 |
| 18. Motor vehicle accidents | .55 | .70 | .65 | .78 | .93 | .89 | .30 | .41 | .39 |
| 19. All other accidents | .62 | .63 | .56 | .77 | .76 | .69 | .35 | .35 | .33 |
| 20. Suicide | .22 | .26 | .30 | .31 | .34 | .42 | .12 | .18 | .18 |
| 21. Homicide | .13 | .23 | .26 | .09 | .16 | .22 | .04 | .06 | .09 |

Chart 34 shows the 15 leading causes of death for persons 65 to 74, 75 to 84, and 85 years or older in 1980. It should be noted that data for causes of death are based on information taken from death certificates and that, frequently, underlying causes are not listed, but a secondary illness will be recorded.

## Chart 34

### FIFTEEN LEADING CAUSES OF DEATH BY AGE GROUP

| | 65-74 | 75-84 | 85 PLUS |
|---|---|---|---|
| 1. | Heart Disease (48.6%) | Heart Disease (44.7%) | Heart Disease (48.8%) |
| 2. | Cancer (Malignant Neoplasms) (27.3%) | Cancer (Malignant Neoplasms) (18.4%) | Cerebrovascular Disease (14.3%) |
| 3. | Cerebrovascular Disease (7.3%) | Cerebrovascular Disease (11.8%) | Cancer (Malignant Neoplasms) (10%) |
| 4. | Chronic Obstructive Pulmonary Disease and Related Conditions (4.3%) | Chronic Obstructive Pulmonary Disease and Related Conditions (3.4%) | Pneumonia and Influenza (5.5%) |
| 5. | Diabetes (2.2%) | Pneumonia and Influenza (3.3%) | Atherosclerosis (4.1%) |
| 6. | Accidents (1.9%) | Diabetes (2%) | Accidents (1.8%) |
| 7. | Pneumonia and Influenza (1.9%) | Atherosclerosis (1.9%) | Chronic Obstructive Pulmonary Disease and Related Conditions (1.7%) |
| 8. | Chronic Liver Disease and Cirrhosis (1.4%) | Accidents (1.8%) | Diabetes (1.4%) |
| 9. | Nephritis, Nephrotic Syndrome and Nephrosis (.8%) | Nephritis, Nephrotic Syndrome and Nephrosis (1%) | Nephritis, Nephrotic Syndrome and Nephrosis (1%) |
| 10. | Atherosclerosis (.8%) | Flu (Septicemia) (.5%) | Hypertension (.6%) |
| 11. | Suicide (.6%) | Hypertension (.5%) | Flu (Septicemia) (.5%) |
| 12. | Flu (Septicemia) (.5%) | Chronic Liver Disease and Cirrhosis (.5%) | Hernias and Intestinal Obstructions (.4%) |
| 13. | Hypertension (.4%) | Ulcers (Stomach and Duodenum) (.4%) | Ulcers (.3%) |
| 14. | Benign Neoplasms (.3%) | Hernia and Intestinal Obstructions (.3%) | Nutritional Deficiencies (.3%) |
| 15. | Ulcers (Stomach and Duodenum) (.3%) | Benign Neoplasms (.3%) | Gallbladder Disorders (.3%) |
| | All other causes (9.3%) | All other causes (9.4%) | All other causes (8.9%) |

SOURCE National Center for Health Statistics, unpublished tabulations

The factors which have led to reductions in mortality may or may not also lead to reductions in disease and chronic illness. If we continue to live only to about age 85 changes could produce a healthier older population, but if we survive in future years, on average, beyond the age of 85, they could also mean a delay in the onset of illness without an actual shortening of the period of illness.

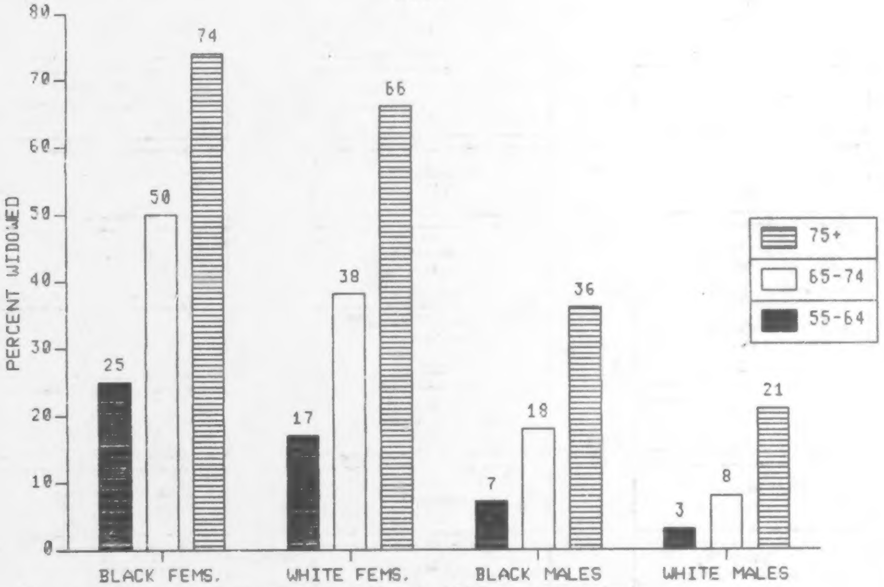
## D. SOCIAL AND OTHER CHARACTERISTICS

### 1. Most Elderly Women Are Widowed and Live Alone, While Most Elderly Men Are Married and Do Not Live Alone

Patterns of living arrangements and marital status differ sharply between elderly men and women. Eighty-three percent of elderly men live in a family setting and more than 75 percent are married and living with their wives. Almost 60 percent of the women live in families but only about 40 percent are married and living with their husbands. Elderly women are more likely to be widowed than married, and a substantial proportion live alone. Fifty percent of elderly women are widowed compared with about 13 percent of elderly men. The disparity is more dramatic at older ages; a remarkable 70 percent of 75-plus women are widowed while 70 percent of 75-plus men are married (chart 35).

Chart 35

WIDOWHOOD OF PERSONS 55 AND OVER BY RACE AND SEX
1983

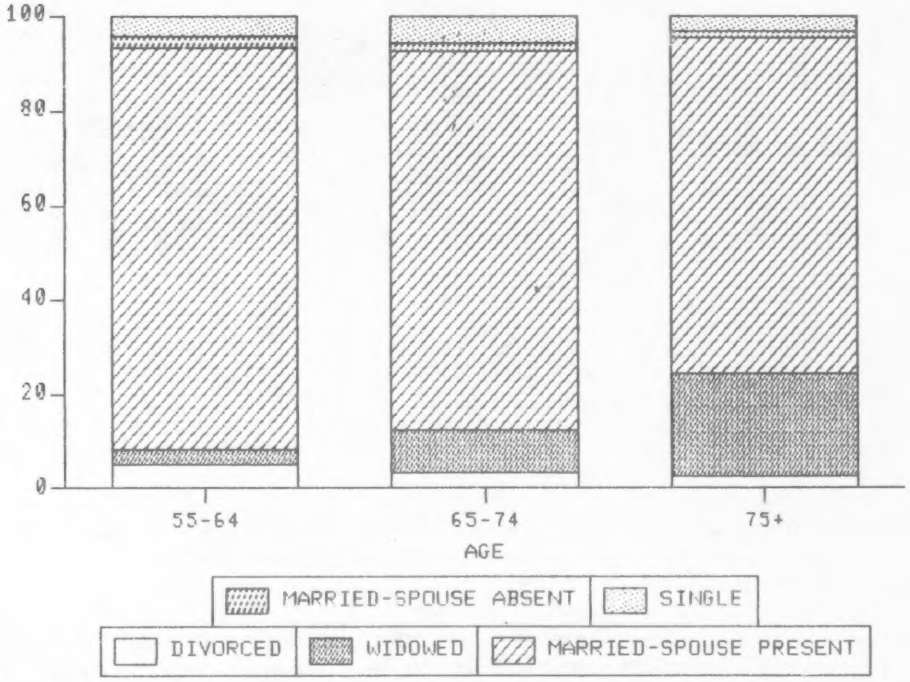


Source: Bureau of the Census, March 1983, unpublished

In 1983, 85 percent of older men in the 55 to 64 year age range were married with their spouse present (chart 36). This figure was 79.8 percent for persons in the 65 to 74 age range and dropped to 70.8 percent for men 75 years or older. Only 67.6 percent of older women in the 55 to 64 age range, however, were married with a spouse present (chart 37). This figure drops to 48.8 percent for women in the 65 to 74 age range and to 23.9 percent for women 75 years or older.

Chart 36

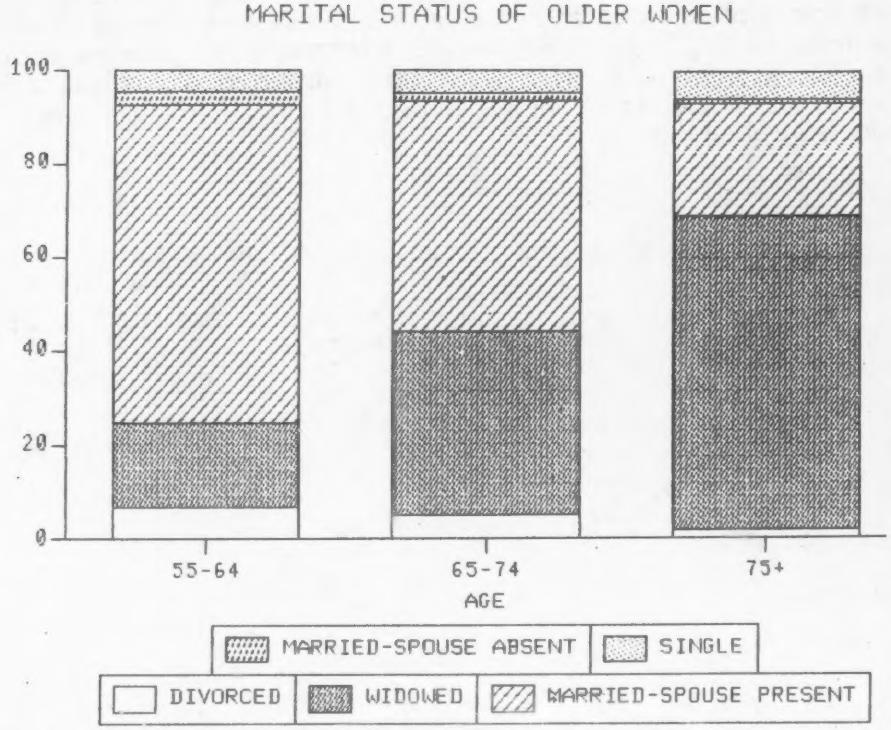
MARITAL STATUS OF OLDER MEN



Source: U.S. Bureau of the Census, Current Population Survey, March, 1983, unpublished data

These differences are due to the combined effects of the higher age-specific death rates of adult men and of the tendency for men to marry younger women. Elderly widowed men have remarriage rates which are about seven times higher than those of women.[36] The "average" widow who has not remarried is 65 years old, has been widowed for 6 years, and can expect to live an additional 19 years as a widow.

Chart 37



Source: U.S. Bureau of the Census, Current Population Survey, March, 1983, unpublished data

In 1983, 5 percent of elderly men and 5 percent of elderly women had never married, and 3 and 4 percent respectively were divorced, an increase since the 1960's.

Elderly white males had the highest probability of being married, elderly black females the least. In addition, once married, black females were most likely to be widowed, white males the least. Black persons were much more likely to be either single, separated, or divorced than were white persons.

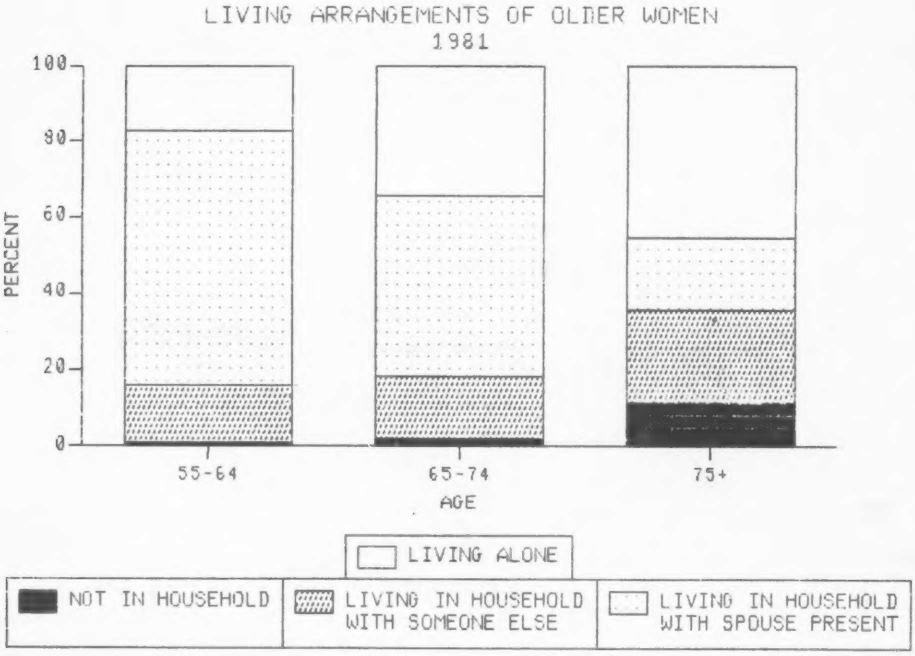
An increasing number of older persons live alone rather than in families. In 1950, 14.4 percent of all persons 65 years and older lived alone, but by 1982 this number had increased to close to 33 percent of the older population. Of the nearly 8 million elderly persons living alone in 1982 (about 30 percent of the elderly popula-

---

[36] U.S. Dept. of Commerce. Bureau of the Census. Jacob S. Siegel. Demographic Aspects of Aging and the Older Population in the United States. Series P-23, No. 59. Washington, U.S. Govt. Print. Off., 1982, pp. 45, 47.

tion), most were women. Forty percent of elderly women lived alone as compared with 14 percent of elderly men. Of those 75 years and over, half of the women and about 20 percent of the men lived alone (charts 38 and 39).

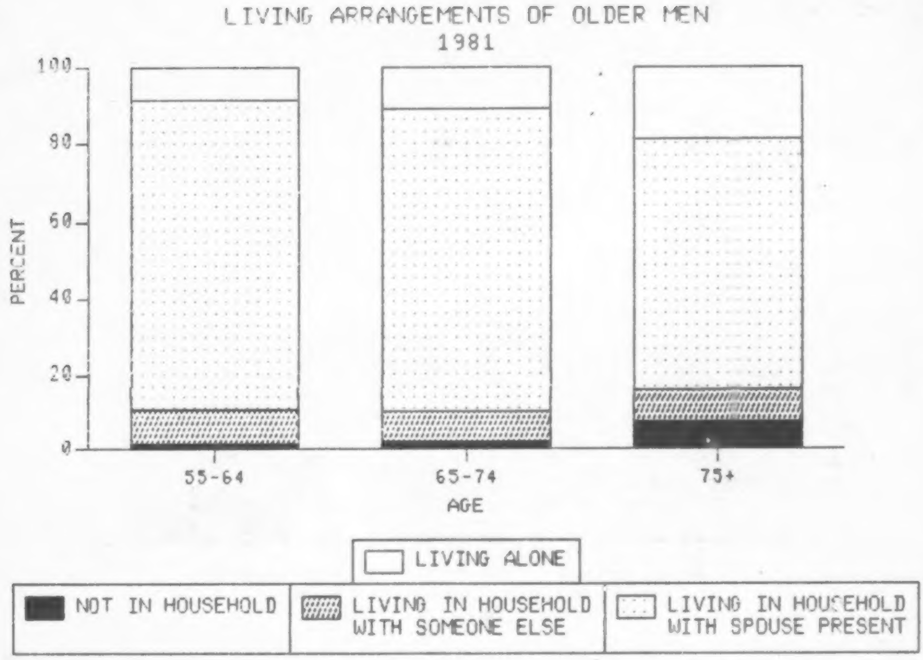
Chart 38



Source: U.S. Bureau of the Census, Current Population Survey, March, 1982

Relatively small numbers of elderly live in intergenerational households with children or with other relatives, although this percentage does increase with advancing age, particularly for older women.

Chart 39



Source: U.S. Bureau of the Census, Current Population Survey, March, 1982

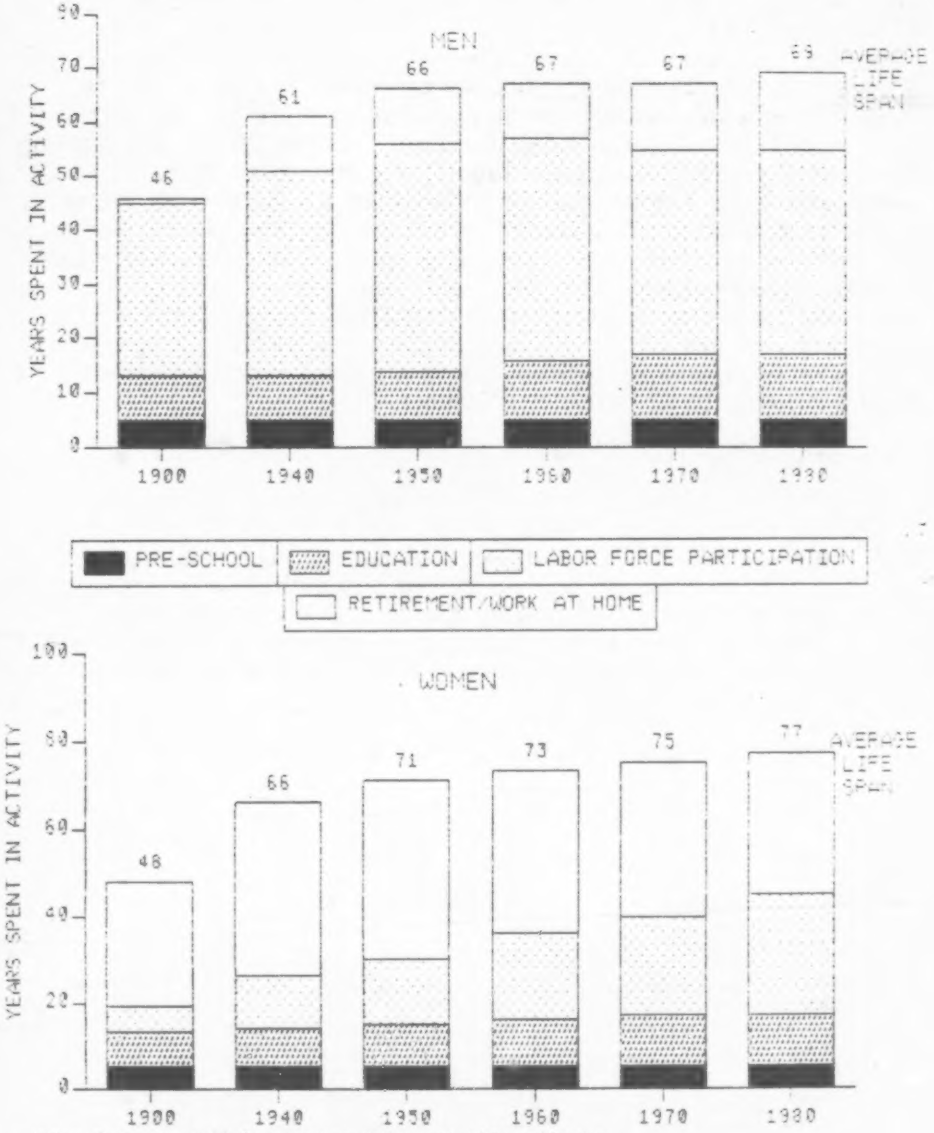
## 2. Retirement Is No Longer a Luxury, It Is Now an Institution

Due to increased longevity and changing social and work patterns, this century has seen dramatic changes in the distribution of individuals' time devoted to major life activities such as education, work, retirement, and leisure. Today, children are spending more time in school, both men and women in the middle years are spending more time in work, and older people are spending more time in retirement.

Retirement is now as much an expected part of a life course as family, school, or work. The portion of life spent in retirement has increased substantially since the beginning of this century (chart 40). In 1900, the average male had a lifespan of 46.3 years. An average of 1.2 years, 3 percent of his lifespan, was spent in retirement. By 1980, the average male had a lifespan of 69.3 years, and he was spending 13.8 years, 20 percent of his lifetime in retirement.

## Chart 40

LIFECYCLE DISTRIBUTION OF EDUCATION, LABOR FORCE PARTICIPATION, RETIREMENT AND WORK IN THE HOME: 1900-1980



Note: Data for 1980 is based on 1977 work life estimates
Source: "Median School Years Completed", Bicentennial Edition: Historical Statistics of the United States; Work Sharing: Issues, Policy Options and Prospects, Upjohn Institute for Employment Research, 1981; Bur. of Labor Statistics Bulletin 1982. Life expectancy from U.S. Bureau of the Census

In 1980, males averaged over 5 more years in the labor force than in 1900. However, a smaller portion of their life cycle was spent in the labor force, 55 percent, than in 1900 when males spent 69 percent of their lifespan working.

The number of years spent in school also increased for males from an average of 8 years to 12.6 years from 1900 to 1980. However, the proportion of time devoted to education only increased from 17 to 18 percent.

Change in distribution patterns of major life activities are very different for women (chart 40). As more women have entered the labor force, a dramatic increase has taken place in the portion of time spent in work outside the home. Since 1900, the average number of years spent in the labor force increased from 6.3 to 27.5 years and from 13 percent of the lifespan to 36 percent. However, one caveat must be mentioned; the data for labor force participation of women is necessarily skewed by the fact that, historically, women have worked within the home and have tended to interrupt their work during child-rearing years. Dramatic reductions in such interruptions are reflected in the decrease in the proportion of time women spend in retirement or work at home (60 percent in 1900 compared to 42 percent in 1980).

## 3. EDUCATION GAP BETWEEN OLDER AND YOUNGER PERSONS IS CLOSING

Although educational attainment of the elderly population is well below that of the younger population, the gap in median school years completed has narrowed somewhat over the last 30 years and is expected to nearly close in the next 10 years. Even today, the proportion of the population aged 55 to 64 years which has completed high school in nearly equal that of the younger population (table 11).

TABLE 11.—YEARS OF SCHOOL COMPLETED BY AGE, RACE, AND SEX, MARCH 1982

| | 8 years or less | High school graduates | College 4 or more years | Median school years completed |
|---|---|---|---|---|
| All races: | | | | |
| Both sexes: | | | | |
| 25 plus | 15.75 | 53.30 | 17.70 | 12.60 |
| 55 to 59 | 17.44 | 51.50 | 14.30 | 12.40 |
| 60 to 64 | 23.23 | 50.00 | 10.80 | 12.30 |
| 65 to 69 | 29.16 | 42.80 | 10.30 | 12.10 |
| 70 to 74 | 38.20 | 35.20 | 9.60 | 10.80 |
| 75 plus | 49.73 | 27.30 | 8.00 | 9.00 |
| Male: | | | | |
| 25 plus | 15.78 | 49.80 | 21.90 | 12.60 |
| 55 to 59 | 18.62 | 44.70 | 19.70 | 12.40 |
| 60 to 64 | 23.95 | 46.20 | 13.70 | 12.30 |
| 65 to 69 | 30.88 | 38.50 | 13.20 | 12.10 |
| 70 to 74 | 40.16 | 31.00 | 12.00 | 10.50 |
| 75 plus | 53.02 | 23.60 | 10.30 | 8.90 |
| Female: | | | | |
| 25 plus | 15.73 | 56.30 | 14.00 | 12.50 |
| 55 to 59 | 16.39 | 57.60 | 9.50 | 12.40 |
| 60 to 64 | 22.62 | 53.20 | 8.30 | 12.30 |
| 65 to 69 | 27.77 | 46.20 | 8.00 | 12.10 |
| 70 to 74 | 36.78 | 38.10 | 7.90 | 10.90 |
| 75 plus | 47.79 | 29.40 | 6.70 | 9.40 |

TABLE 11.—YEARS OF SCHOOL COMPLETED BY AGE, RACE, AND SEX, MARCH 1982—Continued

| | 8 years or less | High school graduates | College 4 or more years | Median school years completed |
|---|---|---|---|---|
| White: | | | | |
| Both sexes: | | | | |
| 25 plus | 14.66 | 54.30 | 18.50 | 12.60 |
| 55 to 59 | 14.92 | 53.90 | 15.20 | 12.50 |
| 60 to 64 | 20.95 | 52.20 | 11.40 | 12.30 |
| 65 to 69 | 25.96 | 45.70 | 10.80 | 12.20 |
| 70 to 74 | 35.10 | 37.30 | 10.30 | 11.30 |
| 75 plus | 47.37 | 28.70 | 8.50 | 9.40 |
| Black: | | | | |
| Both sexes: | | | | |
| 25 plus | 24.66 | 46.10 | 8.80 | 12.20 |
| 55 to 59 | 38.74 | 31.00 | 4.90 | 10.30 |
| 60 to 64 | 45.32 | 29.40 | 3.80 | 9.70 |
| 65 to 69 | 58.95 | 16.30 | 4.70 | 8.40 |
| 70 to 74 | 65.81 | 15.90 | 3.00 | 7.90 |
| 75 plus | 73.98 | 12.00 | 3.40 | 6.60 |

Source: U.S. Dept. of Commerce. Bureau of the Census. Unpublished data from the March 1982 Current Population Survey.

In 1982, the percentage of the population 65 years and over which had graduated from high school (including those who graduated from college) was about 60 percent as great as in the entire population 25 years and over. Nearly 50 percent of the elderly population were high school graduates as compared with nearly 75 percent of the population 25 years and over. About 33 percent of older white Americans and 66 percent of older black Americans never went beyond the eighth grade. About a third of whites between the ages of 60 and 74, and nearly half over the age of 75 never attended high school; among elderly blacks the respective percentages were about 60 and 75. Thirty-three percent of elderly whites completed high school while only about 16 percent of elderly blacks reached that level.

In terms of higher education, about 10 percent of elderly whites attended 4 or more years of college as compared with about 3 percent of elderly blacks. The gap in educational attainment between age groups is expected to narrow significantly over the next 10 years, partly because of the educational opportunities that became available after World War II, and partly because of our history of immigration. Today's elderly population has a much higher proportion of foreign born than does the younger population. The elderly foreign born have a higher rate of illiteracy and lower educational attainment than the native population.

## 4. THE MAJORITY OF ELDERLY PERSONS DO NOT WORK

The labor force participation of men and women drops rapidly with increasing age (table 12). People are considered to be a part of the labor force if they are currently employed or unemployed but actively seeking work. In 1983, 69.6 percent of 55- to 64-year-old men were in the labor force and 41.7 percent of 55- to 64-year-old women. However, for persons 65 years or older these figures dropped to 17.3 percent for men and 8.1 percent for women.

### TABLE 12.—LABOR FORCE PARTICIPATION AND UNEMPLOYMENT RATES BY AGE, AND SEX: OCTOBER 1983 [1]

[In thousands]

| | 55 to 64 years old | | | 65 or more years old | | |
|---|---|---|---|---|---|---|
| | Total | Male | Female | Total | Male | Female |
| Seasonally adjusted: | | | | | | |
| Civilian labor force | 12,043 | 7,143 | 4,901 | 3,091 | 1,839 | 1,252 |
| Labor force participation rate (percent) | 54.7 | 69.6 | 41.7 | 11.9 | 17.3 | 8.1 |
| Number unemployed | 670 | 437 | 233 | 85 | 47 | 38 |
| Unemployment rate (percent) | 5.6 | 6.1 | 4.8 | 2.7 | 2.6 | 3.0 |
| Number employed | 11,373 | 6,706 | 4,668 | 3,006 | 1,792 | 1,214 |
| Not seasonally adjusted: | | | | | | |
| Number employed | 11,486 | 6,766 | 4,719 | 3,076 | 1,840 | 1,237 |
| Employed part time: | | | | | | |
| For economic reasons | 516 | 211 | 305 | 124 | 70 | 54 |
| As a matter of choice | 1,481 | 411 | 1,069 | 1,484 | 776 | 709 |
| Employed full time | 9,489 | 6,144 | 3,345 | 1,468 | 994 | 474 |
| Number unemployed | 575 | 359 | 216 | 94 | 50 | 44 |
| Duration of unemployment: | | | | | | |
| Less than 5 weeks | 176 | 95 | 81 | 24 | 11 | 12 |
| 5 to 14 weeks | 118 | 68 | 50 | 37 | 16 | 21 |
| 15 to 26 weeks | 73 | 42 | 31 | 9 | 7 | 2 |
| 27 or more weeks | 208 | 153 | 54 | 25 | 16 | 9 |
| Average (mean) duration (in weeks) | 29.2 | 32.8 | 23.2 | 22.0 | (2) | (2) |
| Median duration (in weeks) | 14.2 | 19.7 | 9.0 | 9.1 | (2) | (2) |

---

[1] The U.S. labor force includes workers who are employed and actively seeking employment. The participation rate is the percentage or individuals in a given group (e.g., age group) who are in the labor force.

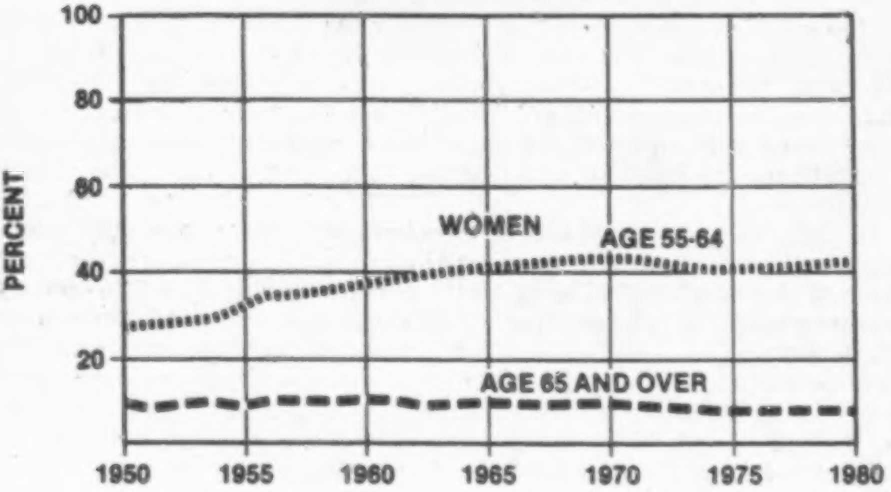
[2] Data not shown where base is less than 75,000.

Source: U.S. Department of Labor. Bureau of Labor Statistics. Current Population Survey. Employment and Earnings for November 1983 and unpublished reports.

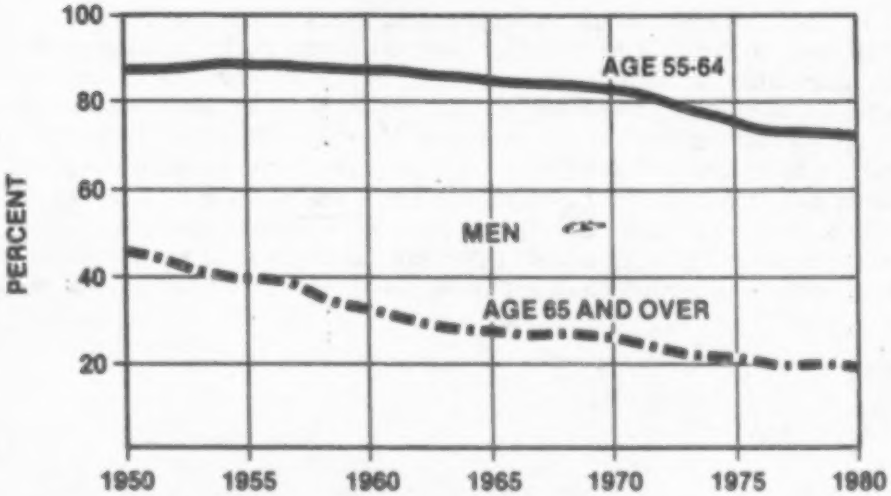
The labor force participation of elderly men has dropped rapidly over the last 30 years (chart 41). In 1950, almost 50 percent of all elderly men were in the labor force; by 1960, only 33 percent were working or looking for work; by 1970, only 25 percent; and by 1983, 17.3 percent (1.8 million). The decreases are due in part to an increase in voluntary early retirement and a drop in self-employment. The decrease in male labor force participation extends even to men in their fifties. In 1960, over 88 percent of males in the 55- to 59-year-old group were in the labor force; by 1982, it had declined to 82 percent. In 1960, 77 percent of men aged 60 to 64 worked, but by 1982, only 57 percent did. At age 70 and over, in 1960, 25 percent of men worked, but by 1982 the proportion had dropped to about 13 percent.

## Chart 41

### LABOR FORCE PARTICIPATION OF WOMEN AGED 55-64 AND 65 AND OVER 1950-1980



### LABOR FORCE PARTICIPATION OF MEN AGED 55-64 AND 65 AND OVER 1950-1980



SOURCE: U.S. Bureau of the Census and U.S. Bureau of Labor Statistics reported in U.S. Senate Special Committee on Aging. Developments in Aging: 1982, Volume One.

Labor force participation of elderly women, on the other hand, has varied little. In 1950, about 10 percent of elderly women worked and by 1982, the percentage had dropped to 8 percent (1.2 million). For women over the age of 70, labor force participation dropped from 6 percent to under 5 percent from 1950 to 1982. But women between the ages of 55 and 64 have increasingly joined the work force. In 1950, only 27 percent of the women worked, but by 1982 the proportion had risen to 42 percent.

Historically, labor force participation of black women has been much higher than that for white women. Over the last 30 years, however, the rates have converged so rapidly that, by 1982, less than 1 percentage point separated the two groups. The extent of labor force participation for older black males is somewhat lower today than the rate for older white men, and it has fallen more rapidly.

In 1981, 50 percent of elderly workers were in white-collar occupations. Sex and race were important determinants of the occupations of the employed elderly. Sixty percent of elderly white women workers were in white-collar professions and about 66 percent of black women workers were service workers, predominantly in private households. About 50 percent of elderly white male workers were in white-collar and 25 percent in blue-collar work. Over 33 percent of elderly black males were blue-collar workers with nearly 25 percent in white-collar jobs and another quarter in service jobs. Farm occupations were more common among the oldest men; nearly 20 percent of black and about 17 percent of white working males 70 years and over were farmworkers, compared with less than 4 percent for all males 25 years and over.

### 5. PART-TIME WORK IS AN INCREASINGLY IMPORTANT FORM OF EMPLOYMENT FOR THE ELDERLY

In 1982, of the elderly who were at work in nonagricultural industries, 48 percent of the men and 60 percent of the women were on part-time schedules as compared with 30 percent of the men and 43 percent of the women in 1960 (table 13). Most who are on part-time schedules report that it is their choice to work part time rather than being forced to work part time for economic reasons.[37] Over the last decade, elderly men have made up 5 to 6 percent of all persons on voluntary part-time work schedules, and elderly women have made up about 4 percent, as compared with women 18 to 64 years old who have made up about 50 to 60 percent of such workers.[38]

---

[37] U.S. Dept. of Labor. Bureau of Labor Statistics. Employment and Earnings for January 1961, 1971, and 1982.

[38] Employment and Training Report of the President, 1981. Table A-25, p. 158.

### TABLE 13.—PERSONS 45 YEARS AND OVER AT WORK IN NONAGRICULTURE INDUSTRIES ON PART-TIME SCHEDULES BY SEX AND AGE: ANNUAL AVERAGES FOR 1960, 1970, AND 1982

[Numbers in thousands]

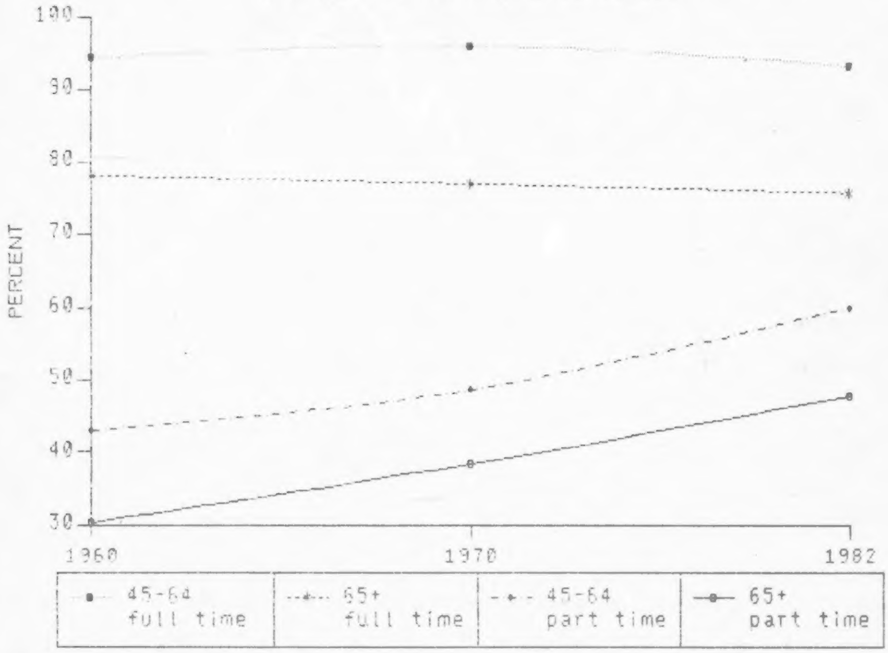
| Sex, age | Number | | | Percent | | |
|---|---|---|---|---|---|---|
| | Total at work | On full-time schedule | On part-time schedule | Total at work | On full-time schedule | On part-time schedule |
| 1982: | | | | | | |
| Males: | | | | | | |
| 45 to 64 | 14,192 | 13,212 | 980 | 100 | 93.1 | 6.9 |
| 65 plus | 1,378 | 717 | 661 | 100 | 52.0 | 48.0 |
| Females: | | | | | | |
| 45 to 64 | 10,235 | 7,525 | 2,710 | 100 | 75.5 | 26.5 |
| 65 plus | 1,011 | 404 | 607 | 100 | 40.0 | 60.0 |
| 1970: | | | | | | |
| Males: | | | | | | |
| 45 to 64 | 14,915 | 14,302 | 613 | 100 | 95.9 | 4.1 |
| 65 plus | 1,536 | 946 | 590 | 100 | 61.6 | 38.4 |
| Females: | | | | | | |
| 45 to 64 | 9,306 | 7,151 | 2,155 | 100 | 76.8 | 23.2 |
| 65 plus | 921 | 473 | 448 | 100 | 51.4 | 48.6 |
| 1960: | | | | | | |
| Males: | | | | | | |
| 45 to 64 | 12,815 | 12,088 | 727 | 100 | 94.3 | 5.7 |
| 65 plus | 1,494 | 1,040 | 454 | 100 | 69.6 | 30.4 |
| Females: | | | | | | |
| 45 to 64 | 7,059 | 5,499 | 1,560 | 100 | 77.9 | 22.1 |
| 65 plus | 784 | 446 | 338 | 100 | 56.9 | 43.1 |

Source: U.S. Dept. of Labor. Bureau of Labor Statistics. Employment and Earnings, for January 1983, January 1971, and January 1961.

For both men and women, the proportion of workers on part-time schedules increases with age. This trend has become increasingly more dramatic in the last two decades (chart 42). For instance, in 1960, 5.7 percent of males 45 to 64 were employed part time while 30.4 percent of males over 65 years were on part-time schedules. Corresponding percentages for 1970 were 4.1 and 38.4. By 1982, 6.9 percent of male workers 45 to 64 worked part time as compared to 48 percent of elderly workers.

Chart 42

PERCENT OF MALE WORKERS IN TWO AGE CATEGORIES
ON FULL AND PART-TIME SCHEDULES



Source: Bureau of Labor Statistics, Employment and Earnings for January, 1960, 1970, 1982

## 6. UNEMPLOYMENT AMONG THE ELDERLY IS AT AN ALL-TIME HIGH

The unemployment rate for the elderly in 1982 (4.7 percent) was about half that of the population 16 years and over. Unemployment among older workers (55 and over) at the close of 1982 (6 percent) was the highest since the Government began measuring joblessness after World War II. More than 770,000 Americans 55 and over were out of work. This figure increases to 1.1 million if discouraged workers who have stopped looking actively for work are included.[39]

Older workers, once they lose their jobs, stay unemployed longer than younger workers, suffer a greater earnings loss in a subsequent job than younger workers, and are more likely to give up looking for another job following a layoff. Persons 55 and over are out of work on the average nearly 20 weeks before being reemployed. That is 23 percent longer than the 15.5 weeks between jobs, on the average, for all unemployed Americans. Likewise, the older worker who successfully finds another job will, on the average, earn $1,500 less than he or she got earlier.[40] Finally, older workers are more than twice as likely as others to give up searching for a new job. There are about 334,000 discouraged workers 55 years and older who are no longer counted as unemployed because they've stopped looking for work.[41]

---

[39] U.S. Dept. of Labor. Bureau of Labor Statistics. Unpublished data, November 1982.

[40] Mincer, J., and H. Ofek. Interrupted Work Careers: Depreciation and Restoration of Human Capital. Journal of Human Resources, v. 17, Winter 1982. pp. 1-24.

## 7. HOUSING

Housing, while an asset for most older people, represents a serious problem for others. In 1980, 72 percent of the households maintained by an elderly person were owner-occupied; about 80 percent were owned free and clear. About 66 percent of all homes owned free and clear are maintained by an elderly person.

Homeownership is most often related to intact families, yet over a third (38 percent) of owner-occupied households were inhabited by older men and women living alone or with nonrelatives. Only 33 percent of renter-occupied units were maintained by elderly persons in families; the other 66 percent were maintained mostly by elderly men and women living alone.

Persons 65 years or older are most likely to live in older homes, whether they rent or own. In 1980, 40 percent of both elderly owners and elderly renters lived in housing structures built in 1939 or earlier. Another 14 percent of elderly owners and 10 percent of elderly renters lived in structures built between 1940 and 1949 (chart 43). By contrast, 22 percent of younger persons who lived in owner-occupied units built before 1939 and another 8 percent lived in units built between 1940 and 1949. Figures for younger renters were similar to elderly renters, 40 percent lived in structures built in 1939 or earlier and 8 percent rented structures built between 1940 and 1949.

While age of housing is not necessarily an index of physical condition, it does bear a relationship to size, functional obsolescence, and ease of maintenance. Various housing studies reveal that many older persons live in homes that are too large for current family size and need. Many elderly with physical handicaps do not have the funds or the availability of services to adapt older, larger homes to their physical needs.

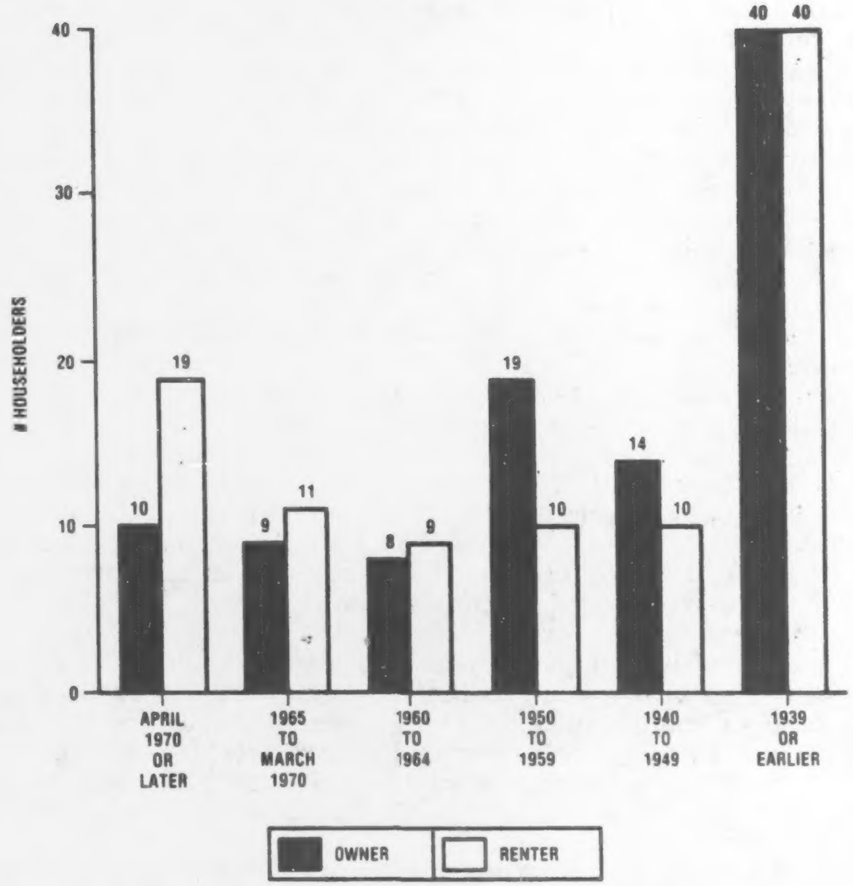
Age of housing also determines net worth. The median value in 1981 of homes built in 1939 or earlier was $39,900 as compared to $79,000 for those built after April 1972.

---

[41] Dept. of Labor. Bureau of Labor Statistics. Unpublished data, November 1982.

Chart 43

YEAR HOUSING STRUCTURE BUILT—
HOUSEHOLDERS 65 YEARS AND OLDER



SOURCE U S Bureau of the Census Annual Housing Survey 1980 unpublished

A significant proportion of both elderly renters and homeowners live in housing with flaws. According to the 1980 Annual Housing Survey, 10 percent of units headed by persons 65 years or older lived in housing with signs of mice and rats and 30 percent lived in housing with bedrooms which lacked privacy (25 percent of elderly owners and 62 percent of elderly renters). Smaller numbers of elderly persons lived in housing with flaws such as incomplete kitchen facilities (2 percent), open cracks or holes (4 percent), and incomplete plumbing facilities (3 percent).

Elderly renters are more likely than elderly homeowners to have moved from one housing structure to another in recent years. According to the 1980 Annual Housing Survey, 68 percent of elderly renters had moved into their present housing unit after April 1970, as compared to 25 percent of elderly homeowners. Fifty percent of elderly homeowners moved into their present homes in 1959 or earlier, while this figure was 13 percent for elderly renters.

## 8. MORE ELDERLY VOTE THAN ANY OTHER AGE GROUP

There are direct relationships between voter participation rates and the demographic and socioeconomic characteristics of the electorate. Higher education levels, employment, white-collar occupations, higher income, homeownership, and duration of residence in the community are all characteristics associated with high voter participation.

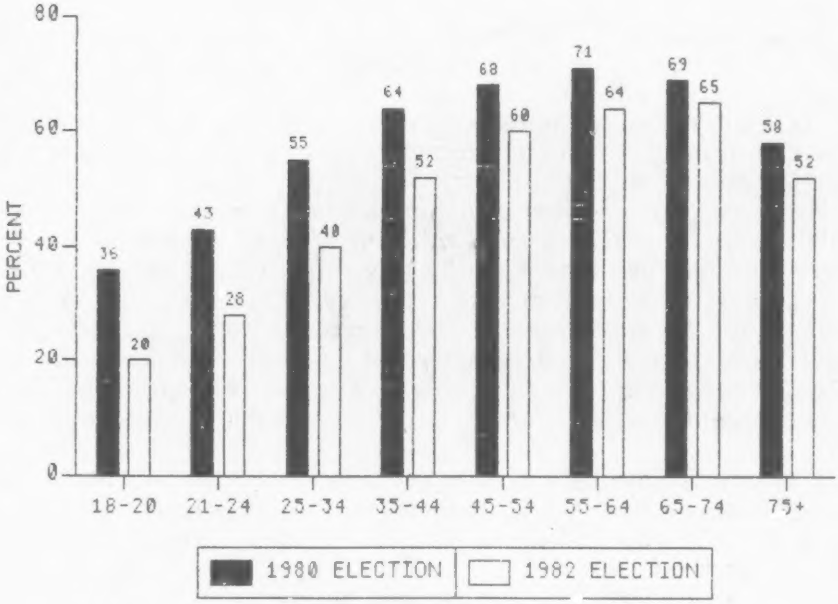
However, voting rates also increase with age. In the November 1980 election, one-third (30.7 million) of those who reported voting were 55 years or older. Of all age groups, voters age 55 to 64 had the highest participation rate (71 percent); with the 65- to 74-year-old group the next highest (69 percent). Voting participation is lower among the aged—58 percent of those 75 and over voted. These figures compare favorably to the rate of voter participation (59.2 percent in 1980) for the total population 25 and over (chart 44).

The same relationships between older and younger voters held in the November 1982 midterm election, although in the election persons 65 to 74 voted at about the same rate as persons 55 to 64 (65 and 64 percent, respectively). Fifty-two percent of persons 75 and over voted in 1982. The typical decline in voting in midterm elections is also affected by age; the difference in voter participation is substantially greater among younger voters than older. Thirty-seven percent of all voters in 1982 were 55 years of age or older (29.5 million). Over all age groups, the voter participation rate in 1982 was 48.5 percent.

In both elections, among the elderly, white men were the most likely to vote, followed by white women, then black men and black women. Among the elderly who were registered to vote in 1980 but did not, 40 percent attributed the cause to illness. About 20 percent of all registered voters did not vote because of lack of interest or lack of preference for either candidate, but the elderly mentioned these reasons only about half as often. (This information is not available for the 1982 election.)

Chart 44

PERCENT REPORTED VOTING IN 1980 AND 1982 ELECTIONS BY AGE GROUP



Source: U.S. Bureau of the Census, Current Population Surveys, 1981 and 1983

## E. SUMMARY

The older population is growing faster than the rest of the population and will be an increasing proportion of the U.S. population over the next 50 years. But the implications of this fact for American society and Government are not clear without differentiation of the trends. Older Americans are not now and will never be a homogenous group subject to sweeping generalizations. Improvements in income and longevity, for example, that have taken place over the last two decades have made the earlier years of retirement much better today than in 1960. But the situation is quite different for the very old population. This group has both a lower average income and a much greater need for health services and living assistance than do younger age groups. Similarly, widows living alone and most minority elderly face very different and more difficult situations today than do married, white elderly couples.

While America, as is also true for the rest of the world, is today an aging society, the rate of change will be an uneven one. Essentially, we will enjoy a period for the next 30 years when there will be sustained but undramatic growth in the elderly population. But then, in 2010, there will come a remarkable surge in the numbers of older persons as the postwar baby boom matures. In less than 30 years, an aging society will be upon us, whether we have prepared for it or not. If we anticipate and plan for this momentous social event now, individuals and families can still adjust their own expectations and plan for their futures. The foreseeably great magnitude of these events challenges our capacity to adapt public policy far enough in advance to be successful and sets the overall context for the decisions made today regarding the aged and aging in America.

# Chapter 2

# ECONOMIC PERFORMANCE AND THE FEDERAL BUDGET

## A. U.S. ECONOMIC PERFORMANCE DURING 1983 [1]

Economic activity was surprisingly strong during 1983. After 4 years of stagnating, the U.S. economy has staged a vigorous cyclical rebound. The resurgence in business activity has been accompanied by a better than expected drop in unemployment and a moderate inflation rate.

In July 1983, the National Bureau of Economic Research's Business Cycle Dating Committee determined that the contraction which began in July 1981 ended in November 1982. However, at the start of 1983, it was not clear that the economy had in fact turned the corner. As is usually the case at cyclical turning points, the data on economic activity was ambiguous. Moreover, any recovery in 1983 was expected to be sluggish. As the 1983 Economic Report of the President observed:

> The pace of the recovery in 1983 will probably be moderate by historical standards. Low capacity utilization rates and the need to rebuild corporate liquidity will restrain capital spending. The worldwide recession and the lagged effect of the appreciation of the dollar will curtail the growth of exports. Continued reductions in the nondefense public sector will limit it as a source of increased aggregate demand.[2]

Private sector forecasts were equally negative.

The recovery did in fact get off to a slow start. During the first quarter of 1983, real gross national product advanced at only a 2.6 percent annual rate. But as the year progressed the pace of economic activity picked up markedly.[3]

In retrospect, the economy's performance during 1983 was a textbook example of the business cycle's recovery phase. The recovery proceeded through several self-reinforcing stages:

—During the final months of the 1981–82 recession, interest rates fell dramatically. For example, the bank prime lending rate dropped from 16.5 percent in June 1982 to 12.5 percent in October 1982. Other short-term rates declined by similar amounts, while long-term rates fell by about 3 percentage points over the same period. These declines were due to an easing of private credit demands as well as a more accommodative stance on the part of the Federal Reserve Board.

---

[1] This section on economic performance was prepared by Barry Molefsky of the Congressional Research Service.

[2] U.S. President (Reagan). Economic Report of the President. Washington, U.S. Govt. Print. Off., February 1983. p. 143.

[3] This paper is based on economic data and other information available as of Jan. 24, 1984. Nearly all of the data presented here are subject to revision.

—Equity prices began to rise at about the same time as interest rates declined. The fall in interest rates made the return on depressed corporate stock prices more competitive and investors began moving funds into the equity markets. A rise in the stock market improved household balance sheets.

—The decline in interest rates also stimulated the credit sensitive sectors of the economy, particularly housing and consumer durables. Housing starts doubled between mid-1982 and mid-1983 and sales of new automobiles rose to their highest level in 4 years.

—Good economic news resulting from the pickup in durable goods sales and the stock market served to strengthen consumer confidence. Consumers began to increase their spending across the board. By the second quarter 1983, personal consumption of nondurable goods (after adjustment for price changes) increased by 6.4 percent, double the 3.2 percent gain posted in the preceding quarter and substantially above the 1.5 percent increase in the fourth quarter 1982.

—The surge in sales depleted inventories. Manufacturing and trade inventories in the spring of 1983 were about 4 percent below the level recorded in summer 1982. Businesses, expecting further sales gains, began ordering new goods and production was stepped up. Greater output requires more labor; employment rises and consequently so does personal income.

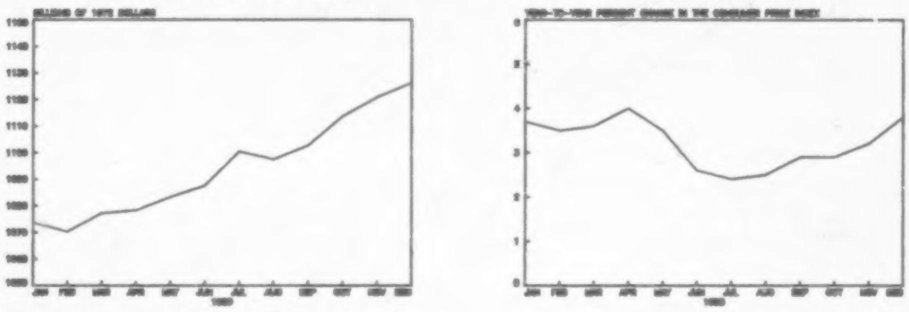
—Rises in income result in even higher sales and trigger increased output. Capacity utilization rises. In order to meet further demand, industry must expand its capacity by increasing investment. At first, higher investment outlays are for motor vehicles, machinery, and other equipment. Later on, spending for construction will pick up. During the second half of 1983, real spending for producers' durable equipment rose by a startling 27.7 percent annual rate. Outlays for nonresidential structures expanded by a mere 3.7 percent.

CHART 1

ECONOMIC PROFILE OF 1983

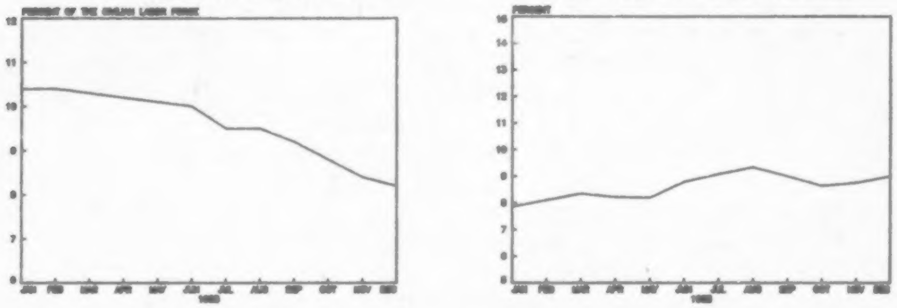
REAL AFTERTAX PERSONAL INCOME

INFLATION RATE



CIVILIAN UNEMPLOYMENT RATE

RATE ON 91-DAY TREASURY BILLS



As 1983 ended, the thrust for further economic expansion was in the process of shifting from consumer spending to business investment. The rate of gain in consumer spending began to moderate while investment outlays began to accelerate.

Far from being sluggish, the 1983 economic recovery turned out to be, basically, average. This can be seen in table 1 which compares the performance of selected economic indicators during 1983 with their average change during the first year of the seven previous postwar recoveries. For most of these indicators, there is little difference between 1983 and the postwar average. There are, however, several indicators where the differences are startling:

—*Corporate profits after tax:* The unusually large increase in after-tax profits (only the recovery from the 1973–75 recession showed a greater gain) is probably due to two factors. First, the change in depreciation enacted as part of the Reagan administration's economic program significantly reduced corporate tax liabilities. Second, industry was able to reduce its costs and thereby boost profitability. Between the first and third quarters of 1983, costs per unit of output fell by more than 1.4 percent; unit labor costs for the nonfarm business sector dropped slightly over the same period.

—*Housing starts:* High mortgage rates crippled the housing industry for several years. In 1981, the effective rate on conventional mortgages rose to over 16 percent. Rates stayed high through 1982, averaging more than 15 percent. At those levels, many families and individuals were locked out of the housing market. When mortgage rates declined to about 13 percent in 1983, new homes became affordable and several years of pentup demand was unleashed. Despite the rise in home construction, however, the level of housing starts is still well below other peak rates achieved in 1978.

TABLE 1.—RECOVERY PROFILES

[Percent change during the first year of economic recovery]

| | Average of seven postwar recoveries | 1983 |
|---|---|---|
| Real gross national product | 7.4 | 6.1 |
| Real disposable personal income | 6.0 | 5.1 |
| Real consumer spending | 5.4 | 5.4 |
| Corporate profit after tax | 41.6 | 63.6 |
| Real nonresidential fixed investment | 8.5 | 11.5 |
| Civilian employment | 2.4 | 3.5 |
| Unemployment rate | [1] −1.2 | [1] −2.1 |
| Nonfarm business productivity | 4.8 | [2] 4.4 |
| Industrial production | 14.0 | 15.3 |
| Housing starts | 11.5 | 34.2 |
| 91-day Treasury bill rate | [1] 1.1 | [1] .9 |
| Standard & Poor's 500 stock index | 20.3 | 21.7 |

[1] Percentage point change.
[2] Based on data through the third quarter of 1983, annually rated.
Sources: U.S. Departments of Commerce and Labor.

One of the remarkable aspects of the 1983 recovery has been the decline in the unemployment rate and the growth in civilian employment. In no other recovery has employment growth been as rapid. But the rise in employment does not fully explain the dramatic decline in the unemployment rate.

Many analysts attribute the more than 2 percentage point drop in the unemployment rate between the fourth quarter 1982 and fourth quarter 1983 to a slowdown in the growth of the labor force.[4] During 1983, the civilian labor force increased by only 1 percent, considerably below the 2.4 percent annual rate of growth experienced during the previous decade. This decline in labor force growth is apparently due to demographic factors, reflecting the declining birth rates of the early 1960's.

Despite the rebound in activity there is still considerable slack in the economy. The unemployment rate may have declined much more than expected, but more than 8 percent of the labor force, or over 9 million people, is still jobless. In addition, the gap between actual and potential gross national product was about 9 percent in the last quarter of 1983. This is very high by historical standards and suggests that there are still substantial unused resources. One beneficial byproduct of this economic slack is that it tends to dampen upward price pressures.

---

[4] For example, see: Tatom, John A. National Economic Trends. Federal Reserve Bank of St. Louis. December 1983. p. 1.

The rate of inflation continued to moderate in 1983. As measured by the Consumer Price Index for All Urban Consumers (CPI-U), the 1983 inflation rate was only 3.2 percent, the smallest rise since 1967. Table 2 below presents the 1982 and 1983 rates of gain in selected components of the CPI-U. All of the major components of the CPI-U rose at a slower rate in 1983 than in 1982. Energy was a major contributor to the easing in inflation. There continued to be an oversupply of energy products. For the first time in its history, in March 1983 the Organization of Petroleum Exporting Countries was forced to cut its price for crude oil. The weakness in the energy market was a large factor in the slowing of the CPI-U's housing (which includes household fuels) and transportation components.

TABLE 2.—CONSUMER PRICE INDEX FOR ALL URBAN CONSUMERS

[Percent change from previous year]

| | 1982 | 1983 |
|---|---|---|
| All items | 6.1 | 3.2 |
| Food and beverages | 4.1 | 2.2 |
| Housing | 7.3 | 2.7 |
| Apparel and upkeep | 2.6 | 2.5 |
| Transportation | 4.1 | 2.4 |
| Medical care | 11.6 | 8.7 |
| Entertainment | 6.5 | 4.3 |
| Special indexes: | | |
| Energy | 1.5 | .8 |
| All items less food | 6.6 | 3.4 |
| All items less shelter | 5.7 | 3.7 |

Source: U.S. Dept. of Labor. Bureau of Labor Statistics.

Whether by good fortune or good planning, Government economic policy tended to foster the economic upturn. Fiscal policy was particularly stimulative. During fiscal year 1983 (ending September 30, 1983), the Federal Government's budget deficit approached $200 billion. Without this stimulus, it is unlikely that the recovery would have been as vigorous as it was. The third phase of the 1981 tax cut, which went into effect in July 1983, undoubtedly gave the economy additional forward momentum.

Monetary policy was essentially accommodative. The monetary aggregates grew quite rapidly during the first half of 1983, but this growth slowed materially in the second half of the year. M1, the narrowly defined money stock, rose at a 14-percent annual rate between December 1982 and June 1983, and at a 4-percent rate from July through December 1983. For the year as a whole, M1 grew about 9 percent. At the end of 1983, the various measures of the money supply were all within the target ranges established by the Federal Reserve Board at the beginning of the year.

Interest rates were, for the most part, stable over the course of 1983, albeit at very high levels. At the start of 1983, it had been feared that the latter months of 1983 would see a clash in the financial markets between private and Government demand for credit which would cause interest rates to rise. Such a rise would have retarded private investment and slowed the overall pace of economic activity. But this clash did not occur. There was no increase in business borrowings in 1983, as industry was able to obtain needed funds from internally generated capital. In addition, there was a large inflow of capital from overseas which augmented domestic savings and helped finance the Government's budget deficit.

In summary, during 1983 the economy experienced a better than expected cyclical recovery. The unemployment rate declined sharply while the rate of inflation continued to ease. Nevertheless, at the end of the year there was still a considerable amount of unutilized resources.

## B. THE FEDERAL BUDGET AND OLDER AMERICANS

### 1. The Fiscal Year 1984 Budget Dilemma

In 1983, the Congress and the Reagan administration reached a deadlock on the question of how to reduce record budget deficits. Annual budget deficits have grown from $58 billion to $195 billion in the last 2 years, and the prospect of continued $200 billion or more deficits has become the central issue in the budget debate.

In his fiscal year 1984 budget proposal, the President called for additional social program spending reductions and defense increases, while proposing largely contingent tax increases, to become effective only if continuing deficits were accompanied by economic recovery. More than one-fourth of the proposed tax increases in the budget were social security tax changes proposed by the National Commission on Social Security Reform to solve social security's financing problems.

The President's budget met with a cool reception on Capitol Hill. The Congress balked at further social spending reductions on the heels of substantial reductions already achieved in the fiscal year 1982 and 1983 budgets. Instead Congress proposed, in the First Concurrent Budget Resolution for fiscal year 1984, that over 85 percent of the deficit reduction should be achieved through new taxes. The resolution called for $73 billion in tax increases and $12 billion in reduced outlays over fiscal years 1984–86 (in addition to the social security changes already enacted). The rate of increase in defense spending was lessened to an annual rate of 5 percent above inflation. The only social program spending cuts proposed by the Congress were to be achieved through cost-cutting measures in medicare.

With the completion of the first budget resolution, action on the budget essentially stalled. A reconciliation bill reducing the deficit by $10.3 billion over 3 years (H.R. 4169) passed the House but remained before the Senate when the Congress adjourned in November. More substantial deficit reduction efforts, focused on raising taxes and reducing entitlement spending, were considered by the Senate Finance and House Ways and Means Committees, but were never brought before either chamber.

After adoption of the first resolution, attention shifted to taxes and entitlements, neither of which are subject to the appropriations process. Since changes in the appropriated accounts were not in dispute, Congress was able to enact 4 of the 13 fiscal year 1984 appropriations bills before the beginning of the fiscal year, and 9 of the 13 before the end of the first session.

The stalemate remaining in the Congress over deficit reduction legislation amounted to a standoff between an administration which feared that tax increases would hamper economic recovery, yet which was committed to a major defense build up, and a Congress which had reached its limit on social spending cuts. As the deadlock over the budget set in, interest grew in the Congress in finding a simple, compromise solution balancing tax increases and entitlement cuts. The most seriously discussed option was a proposal to achieve equal revenues and savings by reducing the indexing of both tax brackets and the annual cost-of-living adjustments (COLA's) in non-means tested entitlements. The proposal, referred to as "CPI minus 3" would have increased tax brackets and reduced COLA's by 3 percentage points less than the usual full increase in the Consumer Price Index (CPI).

By the beginning of 1984, the Congress had yet to act on legislation to achieve the targets set in the first budget resolution. Despite the beginnings of an economic recovery in 1983, deficits remain projected to exceed $200 billion a year in the near future. With growing spending and relatively fixed revenues, the prospects are bleak for a reduction in the debt without major changes in current tax and spending policy.

## 2. LONG-TERM BUDGET DYNAMICS

Prior to fiscal year 1982, Federal budget deficits were fairly stable, averaging in the most recent years about $50 billion a year. Federal budget outlays accounted for between 20 and 22 percent of GNP, while revenues equaled 18 to 20 percent of GNP. Federal outlays became a slightly larger share of GNP in the late 1970's than they had been in the early 1970's, resulting in annual deficits exceeding 2 percent of GNP in the last years of the decade.

### TABLE 3.—FEDERAL FINANCES AND THE GROSS NATIONAL PRODUCT, 1966–87

[Dollar amounts in billions]

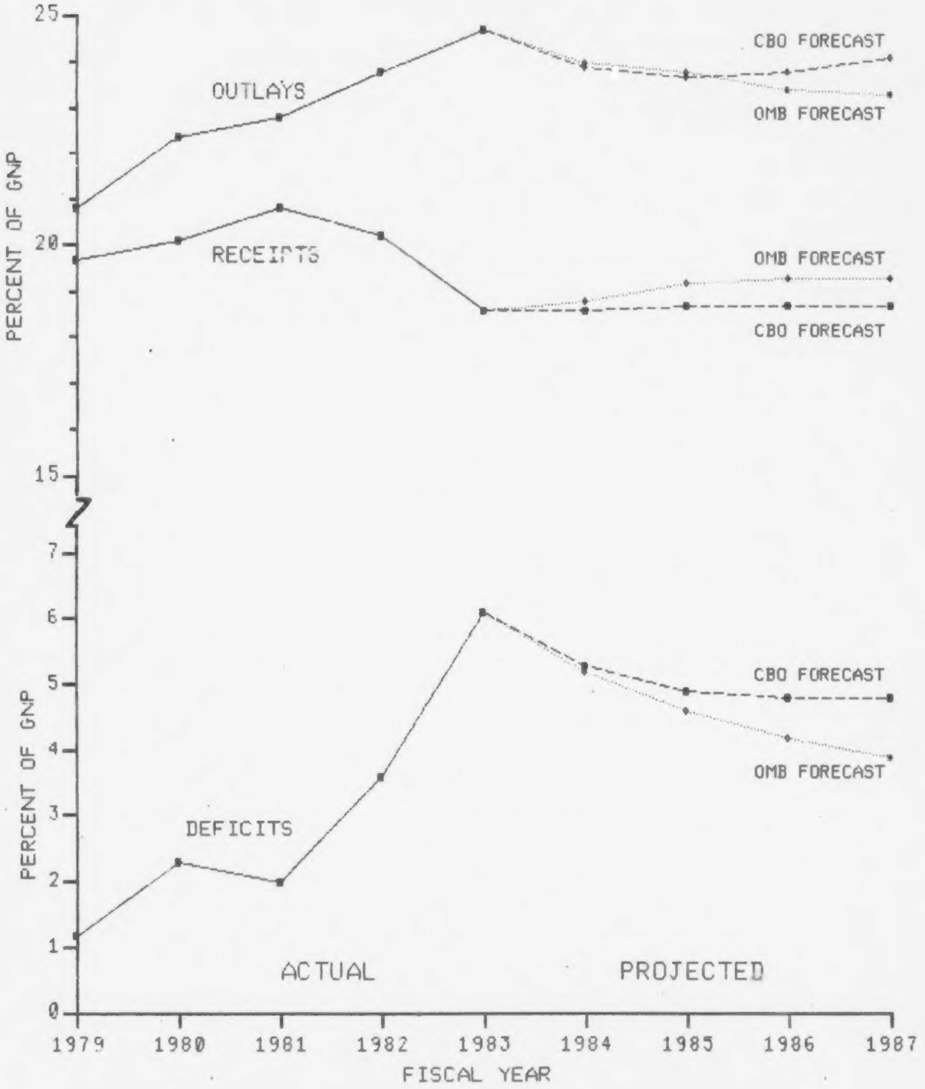
| Fiscal year | Budget receipts | | Budget outlays | | Surplus or deficit(—) | |
|---|---|---|---|---|---|---|
| | Amount | Percent of GNP | Amount | Percent of GNP | Amount | Percent of GNP |
| 1966 | $130.9 | 18.1 | $134.7 | 18.6 | −$3.8 | .5 |
| 1967 | 148.9 | 19.2 | 157.6 | 20.3 | −8.7 | 1.1 |
| 1968 | 153.0 | 18.4 | 178.1 | 21.4 | −25.2 | 3.0 |
| 1969 | 186.9 | 20.5 | 183.6 | 20.2 | 3.2 | .4 |
| 1970 | 192.8 | 19.9 | 195.7 | 20.2 | −2.8 | .3 |
| 1971 | 187.1 | 18.1 | 210.2 | 20.4 | −23.0 | 2.2 |
| 1972 | 207.3 | 18.4 | 230.7 | 20.4 | −23.4 | 2.1 |
| 1973 | 230.8 | 18.4 | 245.6 | 19.6 | −14.8 | 1.2 |
| 1974 | 263.2 | 19.1 | 267.9 | 19.4 | −4.7 | .3 |
| 1975 | 279.1 | 18.9 | 324.2 | 21.9 | −45.2 | 3.1 |
| 1976 | 298.1 | 18.2 | 364.5 | 22.2 | −66.4 | 4.0 |
| 1977 | 355.6 | 19.1 | 400.5 | 21.5 | −44.9 | 2.4 |
| 1978 | 399.6 | 19.1 | 448.4 | 21.4 | −48.8 | 2.3 |
| 1979 | 463.3 | 19.7 | 491.0 | 20.8 | −27.7 | 1.2 |
| 1980 | 517.1 | 20.1 | 576.7 | 22.4 | −59.6 | 2.3 |
| 1981 | 599.3 | 20.8 | 657.2 | 22.8 | −57.9 | 2.0 |
| 1982 | 617.8 | 20.2 | 728.4 | 23.8 | −110.7 | 3.6 |
| 1983 | 600.6 | 18.6 | 796.0 | 24.7 | −195.4 | 6.1 |
| 1984 estimate | 670.1 | 18.8 | 853.8 | 24.0 | −183.7 | 5.2 |
| 1985 estimate | 745.1 | 19.2 | 925.5 | 23.8 | −180.4 | 4.6 |
| 1986 estimate | 814.9 | 19.3 | 992.1 | 23.4 | −177.1 | 4.2 |
| 1987 estimate | 887.8 | 19.3 | 1,068.3 | 23.3 | −180.5 | 3.9 |

Source: Office of Management and Budget. The United States Budget in Brief, Fiscal year 1985. February 1984. Table 8.

Beginning in fiscal year 1982, however, radical changes began to occur in the Federal budget. Federal budget outlays rose substantially, from 22.8 percent of GNP in 1981 to 24.7 percent in 1983, while revenues declined in relative terms, from 20.8 percent of GNP in 1981 to 18.6 percent of GNP in 1983.

## CHART 2

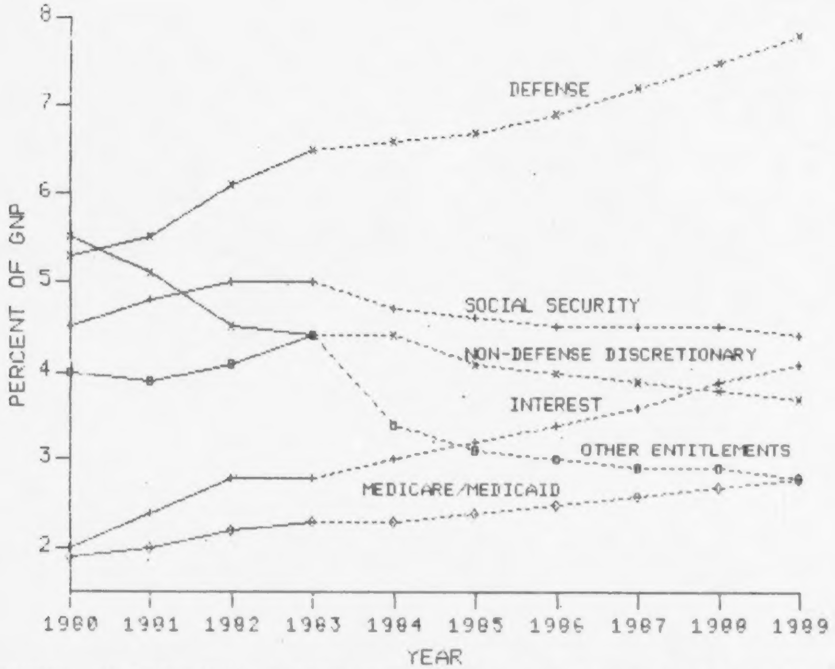
FEDERAL BUDGET AS A PERCENT OF GNP
ACTUAL AND PROJECTED RECEIPTS, OUTLAYS, AND DEFICITS
1979 TO 1987



SOURCES: OFFICE OF MANAGEMENT AND BUDGET. THE UNITED STATES BUDGET IN BRIEF, FISCAL YEAR 1985. TABLE 8. AND CONGRESSIONAL BUDGET OFFICE. BASELINE BUDGET PROJECTIONS FOR FISCAL YEARS 1985-1989. FEBRUARY 1984. TABLE 1.

Rising outlays were driven primarily by large legislated increases in defense spending, which raised the proportion of GNP spent on national defense from 5.5 percent in 1981 to 6.5 percent in 1983. In addition, net interest payments rose as a result of high interest rates and rising deficits, growing from 2.4 percent to 2.7 percent of GNP over this period. Outlays for entitlements (e.g., social security, medicare, Federal pensions) also increased over this period, rising from 10.7 percent of GNP in 1981 to 12 percent in 1983. However, legislation enacted to limit their growth is expected to reduce entitlement outlays to 1981 levels again in 1984.[5]

CHART 3



FEDERAL BUDGET OUTLAYS
ACTUAL AND PROJECTED
1980-1989

SOURCE: CONGRESSIONAL BUDGET OFFICE. BASELINE BUDGET PROJECTIONS FOR FISCAL YEARS 1985-1989. FEBRUARY 1984. TABLE 6

Increases in defense and entitlement spending were substantial enough in the early 1980's to more than offset large reductions in spending for other, largely social, programs. Nondefense discretionary spending declined, largely as the result of large fiscal year 1982 and 1983 budget cuts, from 5.1 percent of GNP in 1981 to 4.4 percent in 1983.[6]

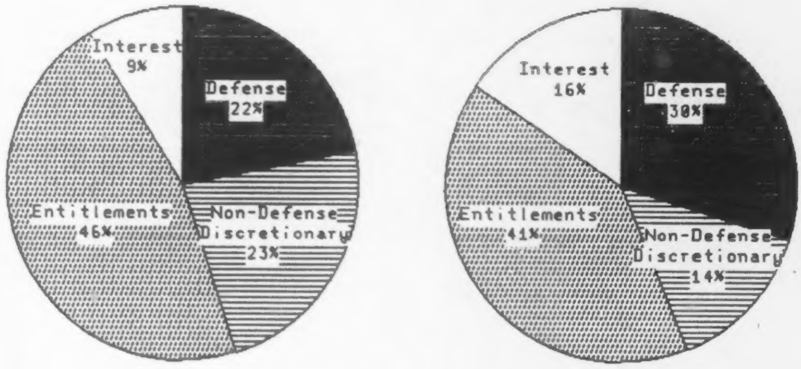
---

[5] U.S. Congressional Budget Office. Unpublished Tables. January 1984.
[6] Ibid.

A substantial shift in spending from social to defense purposes is expected by the end of the decade, without a change in the law. Projections prepared by the Congressional Budget Office (CBO), indicate that outlays are expected to stabilize near 25 percent of GNP for the remainder of the decade. At the same time, defense spending under current law is expected to rise from 6.5 percent of GNP in 1983 to 7.8 percent by 1989, while entitlements and other mandatory spending will decline from 12.4 to 10.6 percent, and nondefense discretionary spending will decline from 4.4 to 3.7 percent. As a result, the portion of the budget dedicated to defense will grow, under current law, from 26 to 30 percent over this period, while domestic spending will decline from 62 to 55 percent.[7]

CHART 4

ALLOCATION OF THE FEDERAL BUDGET
1980 AND 1989



1980
ACTUAL

1989
PROJECTED

SOURCE: CONGRESSIONAL BUDGET OFFICE. BASELINE BUDGET PROJECTIONS FOR FISCAL YEARS 1985-1989. FEBRUARY 1984. FIGURE 6.

The decline in revenues since 1982 has largely resulted from a reduction in tax rates enacted as part of the Economic Recovery Tax Act of 1981 (ERTA). In addition, ERTA authorized a provision indexing the dollar tax brackets to the Consumer Price Index (CPI). This provision, effective in January 1985, will result in a further decline in income tax revenues relative to the economy in the future.

In the last 3 years, the decline in revenues combined with a continuing increase in outlays has nearly quadrupled annual budget deficits. Budget deficits have become the most pressing concern of the Congress, forcing a search for quick and relatively easy sources of revenues or savings. This search has come to focus on entitlement programs not because they are the source of budget deficits, but because they constitute such a large portion of budget outlays, and spending cuts in other areas of the budget have already been achieved or are nearly impossible to achieve. Since the benefactors of most entitlement spending are elderly, it is inevitable that concern would center on the elderly and their burden on the budget.

---

[7] U.S. Congressional Budget Office. Baseline Budget Projections for Fiscal Years 1985–89. A Report to the Senate and House Committees on the Budget—Part II. February 1984. pp. 19–20.

## 3. Federal Spending for Older Americans

The fact that the portion of the Federal budget devoted to older Americans has grown substantially in the past, and is expected to grow in the future, is often used to support the claim that Federal spending for the elderly is out of control. This conclusion is based on a simple and misleading analysis of the role of such spending in the Federal budget. Projected growth in Federal programs benefiting persons over 65 is now almost entirely the result of uncontrolled increases in health spending. It is no longer realistic to assume, as the projections do, that health spending increases at current rates will continue unchecked.

TABLE 4.—FEDERAL OUTLAYS BENEFITING THE ELDERLY [1]

[In millions]

| | 1982 actual | 1983 actual | 1984 estimate | 1985 estimate |
|---|---|---|---|---|
| Medicare-HHS | $42,633 | $48,433 | $56,395 | $64,870 |
| Medicaid-HHS | 6,044 | 6,498 | 6,920 | 7,535 |
| Other Federal health—miscellaneous | 3,010 | 3,456 | 3,725 | 3,991 |
| Health subtotal | 51,687 | 58,387 | 67,040 | 76,396 |
| Social security—HHS | 111,587 | 122,500 | 132,200 | 140,100 |
| Supplemental security income—HHS [2] | 2,686 | 2,907 | 2,535 | 2,676 |
| Veterans compensation—Pensions—VA | 3,901 | 4,413 | 4,627 | 4,890 |
| Other retired, disabled, and survivors benefits—miscellaneous | 19,960 | 20,828 | 22,355 | 23,571 |
| Retirement/disability subtotal | 138,134 | 150,648 | 161,717 | 171,237 |
| Administration on Aging—HHS/USDA [3] | 708 | 730 | 792 | 739 |
| Older American volunteer programs—ACTION | 86 | 88 | 88 | 88 |
| National Institute on Aging—HHS | 89 | 83 | 100 | 112 |
| Senior community service employment program—Labor | 274 | 319 | 317 | 317 |
| White House Conference on Aging—HHS | 3 | 0 | 0 | 0 |
| Subsidized housing (sec. 8/public)—HUD | 3,270 | 3,982 | 4,215 | 4,563 |
| FmHA housing—USDA | 35 | 46 | 50 | 42 |
| Elderly housing loans (sec. 202) [4] | 725 | 765 | 764 | 707 |
| Food stamps—USDA | 541 | 591 | 555 | 524 |
| Nutrition/Puerto Rico [5] | 0 | 41 | 41 | 41 |
| Social services title XX—HHS | 308 | 326 | 366 | 369 |
| Energy assistance—HHS | 589 | 670 | 560 | 560 |
| Other—miscellaneous | 997 | 1,690 | 1,296 | 1,293 |
| Other subtotal | 7,625 | 9,331 | 9,144 | 9,356 |
| Total dedicated elderly resources | 197,446 | 218,365 | 237,901 | 256,989 |
| Percent of total Federal outlays | 27.1 | 27.4 | 27.9 | 27.8 |

[1] Reflects outlays, including effects of proposed legislation, for recipients aged 65 and over in most cases. These are estimates based on Federal agency information—which may be administrative counts, samples, or less accurate estimates from Federal, State and program staff. Other Federal programs that assist the elderly (e.g. consumer activities. USDA extension services. National park services) have been excluded due to data limitations.

[2] Fiscal year 1983 and fiscal year 1988 outlays represent 13-month benefit periods. Fiscal year 1984 outlays reflect an 11-month benefit period.

[3] Includes elderly feeding cash/commodity support from USDA in fiscal year 1982–fiscal year 1984.

[4] Reflects net disbursements for new direct loans.

[5] New program in fiscal year 1983. Fiscal year 1982 and prior year outlays for nutrition assistance/Puerto Rico included in food stamps program outlays.

Source: Office of Management and Budget, February 1985.

Today, about 27 percent of the Federal budget is spent on benefits for older Americans. In all, 40 percent of the Federal budget goes to retirement and health programs which include the elderly as beneficiaries. The share of the Federal budget spent on these programs has increased from 25 percent in 1965, and is projected to increase further to more than 50 percent after the turn of the century.[8] All of this is not spending on the elderly, but the increase in proportion reflects the growing cost of supporting older Americans.

The past growth in spending on the elderly and the growth projected for the future result from two completely different factors. Before the 1980's, the growth in spending on the elderly was largely due to the normal maturing of retirement income programs. As social security and Federal pension programs developed they supported greater numbers of retirees with higher benefit payments for longer periods. In addition, legislated benefit increases in response to high rates of poverty among the elderly raised total payments for social insurance substantially in the late 1960's and early 1970's.

Retirement income spending, however, is no longer a source of growth in spending on the elderly. In the last 2 years, the relative growth in retirement income spending has slowed, and it is now projected to decline for 20 years as a result of stability in the size of the older population, not reaching current levels again until 2030. Social security retirement and disability benefits, which grew from 2.5 percent of GNP in 1965 to 5.2 percent in 1983, are projected to decline to 4.2 percent by 2005 and then increase to 5.7 percent by 2030. Other pension benefits paid from the Federal budget are expected to decline from 2 percent of GNP currently to about 1.2 percent of GNP by 2030.[9]

Today rising health care costs have taken over as the source of increase in Federal spending on the elderly. In 1970, medicare and other Federal health programs accounted for only 1.6 percent of GNP but by 1983 Federal health spending had risen to 2.7 percent of GNP. With no change in the law, increases in health spending are projected to accelerate, resulting in more than 6 percent of GNP going to Federal health spending by 2030.[10] In short, if health care costs are not brought under control, Federal spending on health care will equal, and indeed surpass, Federal spending on retirement income within the next 50 years.

Overall, the share of the Federal budget going to the elderly is expected to remain fairly stable for the next two decades, as declines in retirement income spending offset increases in health spending. Only then should overall spending on the elderly rise as a portion of the budget, and then only if health costs have been allowed to rise unchecked in the interim.

---

[8] Estimates derived from the 1983 Reports of the Trustees of the Old-Age and Survivors Insurance and Disability Insurance Trust Funds and the Hospital Insurance Trust Funds, and other actuarial reports for Federal retirement programs; and based on the assumption that the Federal budget remains fixed in relation to GNP.

[9] Social Security estimates are from the 1983 Report of the Trustees of the Old-Age and Survivors Insurance and Disability Insurance Trust Funds. Table 30. Based on Intermediate II-B assumptions. Additional estimates are from actuarial reports from Federal retirement programs.

[10] Medicare forecasts are from the 1983 Report of the Trustees of the Hospital Insurance Trust Fund.

Even though entitlement spending in its entirety is neither out of control nor even rising in relation to the budget or GNP, there is still pressure to cap entitlement spending to reduce budget deficits. Social security is the largest entitlement program. By itself it is a large and ready source for budget savings—its cash benefits to the elderly now represent 15 percent of the Federal budget and 60 percent of the Federal spending for the elderly.

Although social security cuts could help reduce deficits, it is not likely that benefit cuts can be easily justified. Social security's self-financing generates revenues for the Federal budget which would otherwise not be available. These are revenues dedicated to the payment of social security benefits. To use social security revenues to reduce budget deficits while seeking cuts in social security benefits under the guise of controlling entitlement spending would be difficult to rationalize. This is especially true since the financing of the social security trust funds is now a source of surpluses and is thus already reducing the budget deficit.

Social security is the largest self-financed program, but by no means the only one. In fact, over half of all entitlement spending is self-financed. If expenditures for all partially self-financed programs were excluded from 1982 Federal spending estimates, less than 4 percent of the Federal budget would be devoted to programs assisting the Nation's elderly.

The elderly receive a large share of the Federal budget for good reason. Most of the care that was once theoretically provided to the elderly through their extended families is now provided through mandatory social insurance. While it was relatively easy in a more agrarian society to support older family members, the greater mobility of younger workers and greater life expectancy of surviving elders has made it necessary to provide this support more formally. In the 1930's, the Federal Government accepted the responsibility for taxing younger workers and transferring the tax to those no longer working. This responsibility has become one of the largest and most important activities of the Federal Government. Thus the substantial share of the Federal budget dedicated to the elderly reflects the important role of government in transferring income from workers to their nonworking parents.

# Part I

# RETIREMENT INCOME

After several years of congressional inaction in the face of mounting financing difficulties and budget pressures, 1983 brought a flurry of legislation in the area of retirement income. Social security's short run and long run solvency was restored after a decade of projected deficits, and the railroad retirement system was refinanced to maintain benefit payments to its annuitants. In addition, two pension bills began to move at the end of the first session of the 98th Congress despite the failure of similar legislation in previous Congresses.

For the first time in the 1980's, the significant retirement income legislation was not enacted as part of the annual budget process. Instead, the budget process ground to a halt in 1983, leaving budget reconciliation legislation stranded in the House and Senate. With projections of annual budget deficits near $200 billion a year, however, budget concerns remain predominant. Since retirement income payments to the elderly account for nearly one-fifth of the Federal budget, it is inevitable that proposals to trim retirement income programs will continue to surface in the annual budget debate. To a large extent, these proposals build on a sense that the economic status of the elderly has improved tremendously, surpassing that of the nonelderly in recent years.

## A. ECONOMIC STATUS OF OLDER PERSONS

The recession in 1982 continued the downward pressure on the real incomes of those under 65, and brought the average for this group closer to the average income of older persons. As the income gap between these groups has narrowed, some analysts have begun to contend that the economic status of the elderly now equals or exceeds that of the nonelderly. This contention was reinforced by the fact that in 1982, for the first time since the measurement of poverty began, the poverty rate for the nonelderly actually exceeded the poverty rate for the elderly.

Although the income gap between those older and younger than 65 has clearly narrowed, it is not clear that the elderly are now as a group better off than the nonelderly. Despite substantial improvements in the last 30 years, the cash income of the elderly remains substantially lower than that of the nonelderly. Beyond this simple comparison, the relative economic status of older and younger persons is difficult to evaluate because of differences which exist in the nature of their income, wealth, tax treatment, and consumption patterns. Adjustments made to account for wealth, taxes, and consumption will raise the economic status of some, but not all, older persons. Even with these adjustments, the elderly tend to be concentrated in income ranges just above the poverty level, where they are overlooked for social policy considerations. In the past, justification for special programs for the elderly has been based on the assumption of higher rates of poverty when, in the fact, the major differences now occur just above the poverty line. This section will trace the changing nature of cash income for the elderly and review the current differences in the incomes of the elderly and nonelderly.

## 1. INCOME TRENDS[1]

In 1960, one out of every three older Americans was poor—a rate of poverty twice that of nonelderly adults. Concern over the prevalence of poverty and generally low average income of the elderly brought greater public attention to their income needs and a concerted effort to increase public transfers. Improvements in retirement benefits and a general improvement in the earnings and resources of those reaching retirement over the last two decades have produced a remarkable change in the economic status of the older population. Today, only one older American in seven has an income below the poverty level—a poverty rate now quite close to the rate for nonelderly adults. The transformation in the relative economic status of the elderly has occurred in two distinct periods.

### (A) 1960 TO 1974

Substantial gains in the average income of the elderly occurred during the 1960's and early 1970's due to a general increase in the standard of living, and specific improvements in social security and employer-sponsored pension benefits. Those retiring during this period also benefited from maturation of the retirement income system, having been in the labor force when coverage of workers under retirement income programs expanded in the 1940's and 1950's. Expanding coverage under the plans, granting of past service credits in new plans, rising career wages, and general improvements in benefits helped to raise real benefit levels for each succeeding generation of workers. Those retiring most recently with full or nearly full careers under these programs have, of course, benefited the most.

The most noticeable improvements in the incomes of the elderly came as a result of substantial real benefit increases enacted in social security in the late 1960's and early 1970's. Between 1968 and 1971, ad hoc social security increases raised benefit levels by 43 percent, while consumer prices rose by only 27 percent.[2] The 1972 Social Security Amendments increased benefits by another 20 percent across the board. These changes, added to the effects of maturing retirement income programs and economic growth, narrowed the gap between the elderly and nonelderly considerably.

---

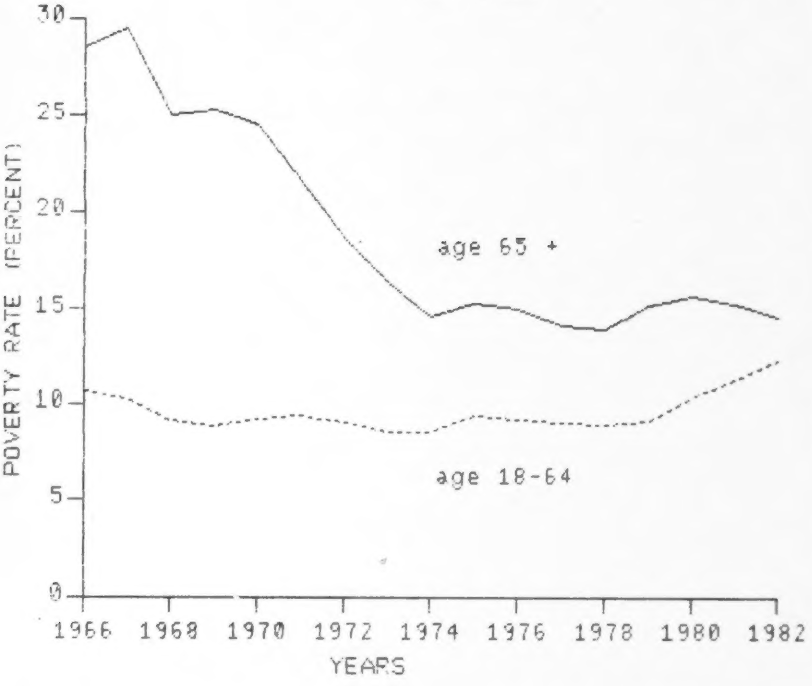
[1] Unless otherwise noted, information on income trends comes from special tabulations of data from the Census Bureau's Current Population Reports—series P-60 for various years, prepared by Tom Bailey of the Congressional Research Service.

[2] Koitz, David. The Indexing of Social Security. U.S. Congress, Senate. Committee on the Budget. Indexation of Federal Programs. 97th Cong., 1st sess. Prepared by the Congressional Research Service, Library of Congress. Washington, U.S. Govt. Print. Off., 1981. p. 143.

The resulting improvement in economic status of the elderly up to 1974 was significant. The poverty rate among those 65 and over was more than halved, declining from 28.5 percent in 1966 to 14.6 percent in 1974. During this period, the poverty rate among nonelderly adults declined less substantially from 10.6 percent in 1966 to 8.5 percent in 1974. The median income for families with a head 65 and older rose in constant (1982) dollars by nearly a third—from $11,356 in 1967 to $14,690 in 1974. Growth in the median income for families with a head under 65 also rose in constant (1982) dollars over this period, but not nearly as rapidly as that of elderly families—from $25,305 in 1967 to $28,147 in 1974.

CHART 1

POVERTY RATES FOR NONAGED AND AGED
1966-1982



SOURCE: CONGRESSIONAL RESEARCH SERVICE, SPECIAL TABULATION FROM U.S. BUREAU OF THE CENSUS, "MONEY INCOME OF FAMILIES AND PERSONS IN THE UNITED STATES," 1983

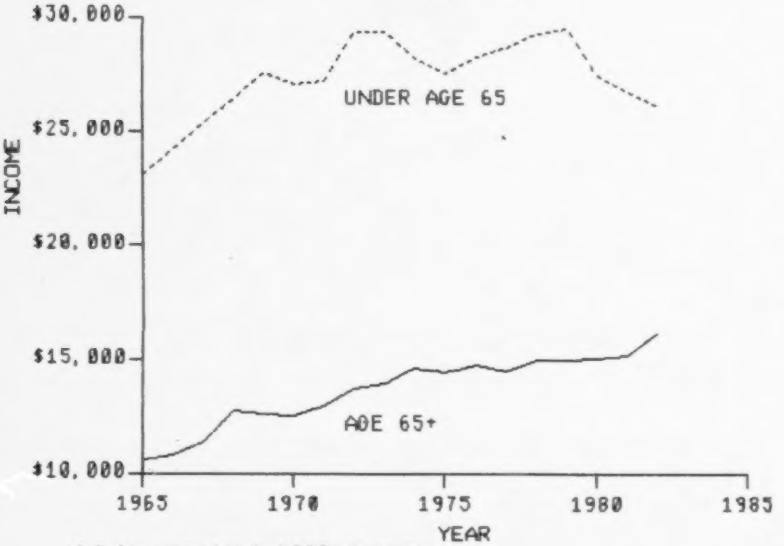
### (B) 1974 TO 1982

By the late 1970's, the general effects of stagnation in the economy brought real income increases for all groups to a halt. While automatic indexing of social security benefits helped protect the real income of the elderly in a period of rapid inflation and slow wage growth, it protected less than 40 percent of total income the elderly received. At the same time, stagnant final pay levels, earlier retirements at reduced benefit levels, declining market prices for some assets, and only partial indexing of most pension benefits dampened any upward trend in retirement income.

As a result, the gap in income between the elderly and nonelderly narrowed only slightly after 1974. The average real income of the nonelderly actually declined somewhat, while the rise in average real income of the elderly slowed significantly. The median income of families with a head under 65 declined in constant (1982) dollars by 5.2 percent from $28,147 in 1974 and to $26,679 by 1981. The median income of families with a head 65 and over increased in constant (1982) dollars by 3.6 percent from $14,690 in 1974 to $15,214 in 1981. In 1982, the downward trend continued for the nonelderly, with a further decline in the median family income to $26,003, while the median income of elderly families rose sharply to $16,118.

CHART 2

MEDIAN FAMILY INCOME 1/
BY AGE OF FAMILY HEAD
1965-1982



1/ in constant 1982 dollars.

SOURCE: CONGRESSIONAL RESEARCH SERVICE, SPECIAL TABULATION FROM U.S. BUREAU OF THE CENSUS, "MONEY INCOME OF FAMILIES AND PERSONS IN THE UNITED STATES."

Poverty rates have shown a similar trend. Poverty rates among those 65 and over have risen only slightly from 14 percent in 1978 to 14.6 percent in 1982, while poverty rates among adults under 65 have risen dramatically from 8.9 percent in 1978 to 12.3 percent in 1982.

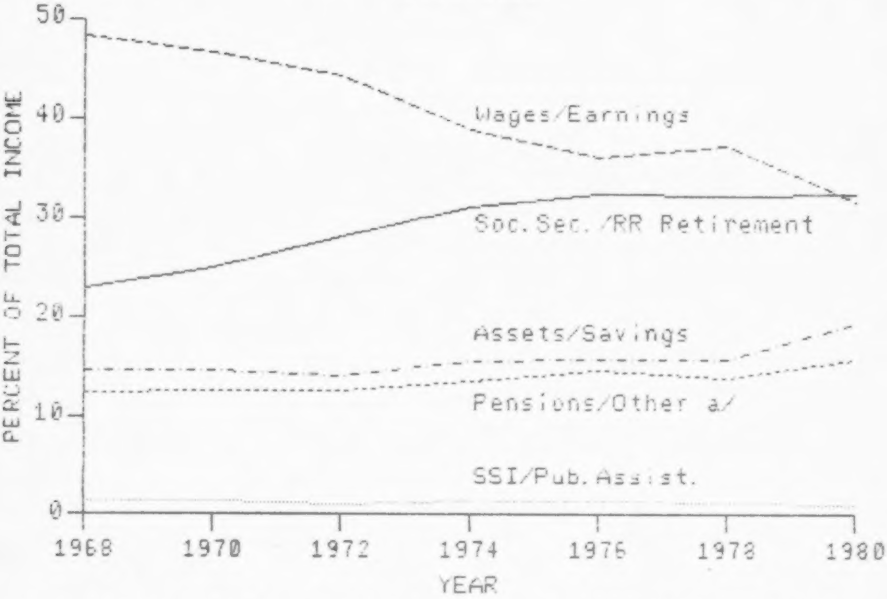
### (C) CHANGING COMPOSITION OF INCOME

The rapid growth in real benefit levels for the elderly during the late sixties and early seventies was accompanied by a substantial change in the composition of income the elderly received. In the late 1960's, families with heads 65 and older derived nearly half of their income from earnings, while only 23 percent of their income came from social security. Now, 20 years later, social security has surpassed earnings as the leading source of income for these families.

A substantial decline in the role of earnings has been the most notable feature of this change. The trend toward earlier ages of retirement among older males has caused labor force participation rates of men 65 and older to drop from 33 percent in 1960 to 19 percent in 1980.[3] As a result, earnings which accounted for 48 percent of elderly family income in 1968 accounted for only 31.5 percent in 1980.

CHART 3

CHANGING COMPOSITION OF FAMILY INCOME
FAMILY HEAD AGE 65+
1968-1980



a/ includes veteran, unempoyment, workers compensation annuities and alimony

SOURCE: CONGRESSIONAL RESEARCH SERVICE, SPECIAL TABULATION FROM U.S. BUREAU OF THE CENSUS, CURRENT POPULATION SURVEYS, 1968-1980.

---

[3] U.S. Dept. of Labor. Bureau of Labor Statistics. Handbook of Labor Statistics. Washington, U.S. Govt. Print. Off., 1983.

Social security grew in importance as a source of income to elderly families between 1968 and 1974, but has remained fixed since then. As a result of legislated benefit increases in 1968, 1970, 1971, and 1972, the proportion of elderly family income coming from social security increased from 23 percent in 1968 to 31 percent in 1974. Since 1974, however, the proportion of elderly family income coming from social security has remained steady. In recent years, a particularly steep decline in the role of earnings has been offset by an increase in the role of assets and pensions as a source of income. This shift was most pronounced between 1978 and 1980, as assets increased from 15.7 percent to 19.4 percent and pensions grew from 13.8 to 15.8 percent of income.

## 2. Current Economic Status[4]

Although poverty rates among the elderly and nonelderly are now similar, larger proportions of the elderly remain clustered just above the poverty line. While the elderly receive more economic advantage than the nonelderly from the tax treatment of income, government in-kind transfers, lifetime accumulations of wealth, and family size; these factors do not entirely offset the generally lower cash incomes of the elderly. When all factors are considered, the elderly remain more likely than the nonelderly to be only barely removed from poverty. The following analysis reviews new information on the effect of these factors on the distribution of income among the elderly and nonelderly.

### (A) CASH INCOME

When compared strictly on the basis of money income, older persons, on average, receive substantially less income than those under 65. In 1982, the median income of families having at least one member age 65 or older was $17,216, about 70 percent of the median income ($24,966) of families with no elderly members. The median income of elderly individuals not living in families was $6,367, about half that of nonelderly individuals ($12,246).

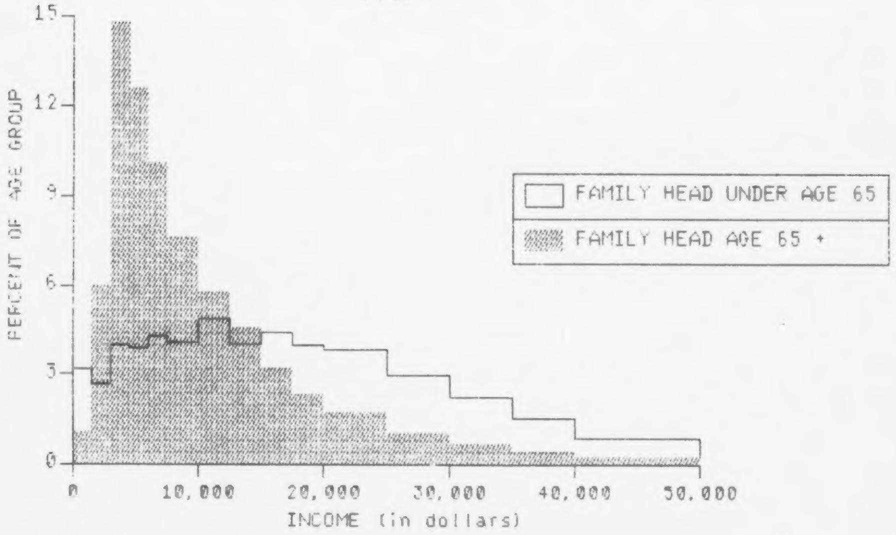
The average of elderly income is low due to an extremely large concentration of older persons at very low levels of cash income. The distribution of cash income among the elderly is substantially more unequal than the distribution among the nonelderly. In 1980, 57.3 percent of the families with heads 65 and older has cash incomes below $10,000, compared to only 24.9 percent of the families with heads under 65. The concentration of older families was greatest between $3,000 and $6,000, but was particularly small at the lowest income level (under $1,500). Nonelderly families, on the other hand, were fairly evenly distributed across the low-income ranges. The tendency of older families to cluster at incomes just above the lowest income range is evidence of the effect of the income floor provided through SSI. Very poor younger families have no similar form of income protection.

---

[4] Information on 1982 income status and poverty comes from special tabulations of the Census Bureau's March 1983 Current Population Survey [CPS], prepared by Tom Bailey of the Congressional Research Service. Information on comparisons of elderly and nonelderly income in 1980 comes from tabulations prepared for the committee by ICF, Inc., using a modified March 1981 CPS.

CHART 4

CASH FAMILY INCOME
(BEFORE TAXES)
1980



SOURCE: ICF INCORPORATED, "BACKGROUND DATA ON THE RELATIVE ECONOMIC STATUS OF THE ELDERLY AND NON-ELDERLY IN 1980," FEBRUARY 1984.

### (B) POVERTY

The poverty rate is one regular measure of relative income which adjusts for variations in need. The poverty rate measures the adequacy of money income in relation to a minimal level of consumption, fixed in real terms and adjusted for family size.

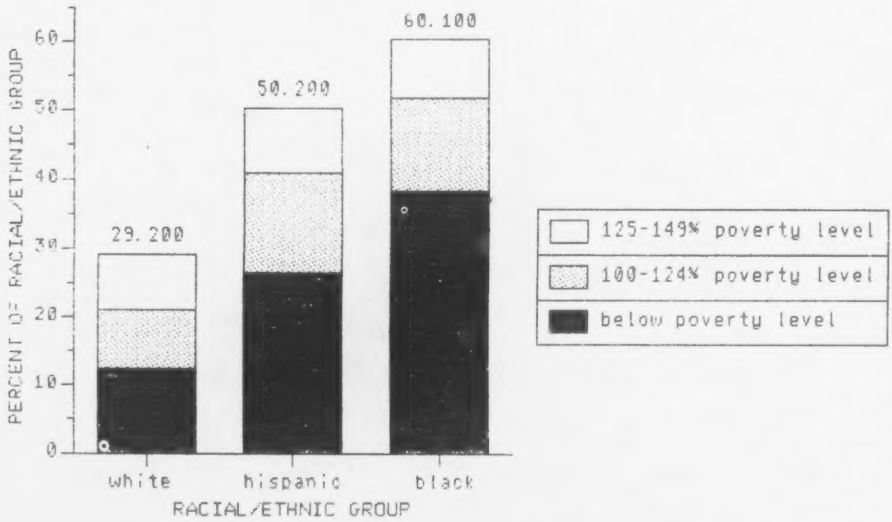
Traditionally, larger proportions of the elderly than the nonelderly have been unable to attain this minimal level of consumption. However, in 1982, the deepening recession caused poverty rates for the nonelderly to exceed the elderly poverty rate for the first time. The rise in poverty among the nonelderly was substantial. Nearly 3 million more nonelderly adults and children were below the poverty level in 1982 than there had been in 1981. The poverty rate among the nonelderly—at 15 percent—was more than 1 percent higher than the poverty rate of 13.9 percent in 1981. At the same time, the number of elderly with income below the poverty level remained steady—varying slightly from 3.9 to 3.8 million—while the elderly poverty rate reversed an upward trend of recent years, declining from 15.3 to 14.6.

Poverty is, of course, not uniform among the elderly. Rates of poverty are lowest among the younger elderly and among whites, particularly white males. The incidence of poverty increases among older persons with advancing age. For example, the poverty rate for persons between the ages of 65 and 74 was 12.4 percent compared to 17.4 percent for those between the ages of 75 and 84, and

21.2 percent for those age 85 and over. The incidence of poverty was also higher for females than males—17.5 percent of elderly females were poor compared to only 10.4 percent of elderly males. Black elderly had a poverty rate (38.2 percent) three times as that of white elderly (12.4 percent). Hispanic elderly also had a poverty rate (26.6 percent) higher than that of white elderly. Older persons living in a family had a lower incidence of poverty than elderly individuals. Only 8.5 percent of the elderly who lived in families were poor, compared to 27.1 percent of those living outside a family setting.

CHART 5

POVERTY STATUS OF PERSONS AGE 65+
PERCENT DISTRIBUTION BY RACE AND ETHNICITY
1982

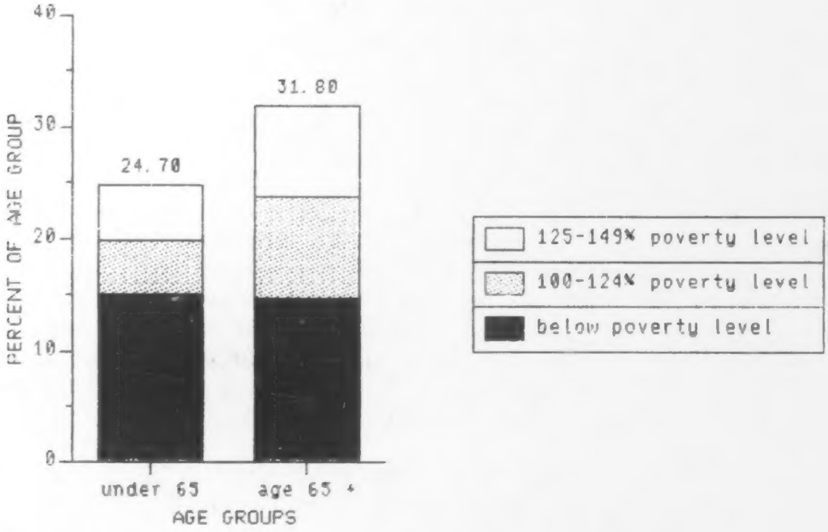


SOURCE: CONGRESSIONAL RESEARCH SERVICE, SPECIAL TABULATION FROM U.S. BUREAU OF THE CENSUS, "MONEY INCOME OF FAMILIES AND PERSONS IN THE UNITED STATES," 1983

Poverty is a limited measure of relative economic status, focusing only on those with income so low they are unable to meet minimal food needs. It is not surprising to find that at the very lowest income levels, the elderly are somewhat better protected than the nonelderly because only the elderly benefit from a uniform Federal income floor available in the SSI program. At levels just above poverty, however, there remains a significantly greater concentration of older persons. In 1982, nearly one older person in three had an income within one and a half times the poverty level, compared to only one in four younger persons.

CHART 6

POVERTY STATUS OF PERSONS BY AGE
PERCENT DISTRIBUTION
1982



SOURCE: CONGRESSIONAL RESEARCH SERVICE, SPECIAL TABULATION FROM THE U.S. BUREAU OF THE CENSUS, CURRENT POPULATION SURVEY, MARCH 1983

### (C) TAX TREATMENT

The elderly generally pay a smaller portion of their income in taxes than do the nonelderly. As a result, when tax payments are taken into consideration, the net incomes of the nonelderly tend to be reduced somewhat, while the net incomes of the elderly remain relatively unchanged.

Several features of the tax system advantage the elderly. As a matter of public policy, there are four special tax provisions aimed at reducing the tax burden of older taxpayers: (1) The exclusion of social security, railroad retirement, and veterans pension income; (2) the additional exemption for the elderly; (3) the elderly tax credit, targeted to low-income individuals with little or no social security; and (4) the one-time exclusion of capital gains from home sales.

While these four special tax provisions aid the elderly, it is not clear that they result in a substantial income advantage for the elderly relative to other groups. Treasury estimates indicate that, in 1981, the tax loss resulting from the special treatment of elderly income cost the Treasury $18.3 billion—only 14 percent of the total tax loss from personal income tax exclusions and deductions (not including the exclusion of employee benefits).[5] The tax advantage benefiting the elderly will lessen in 1984 as a result of taxing half of the social security benefit of higher income individuals.

---

[5] U.S. Congress. Senate. Special Committee on Aging. Developments in Aging: 1982, v. 1. 98th Cong., 1st sess. Washington, U.S. Govt. Print. Off. pt. I, ch. 2, table 7, from a study completed by the U.S. Treasury and released by the U.S. Congress, Joint Economic Committee, November 1982.

Differences in the nature of their income also result in a relatively lighter tax burden for older families than for younger families. First, the elderly pay substantially less in social security taxes because, as a group, they receive little or no income from earnings. Second, the elderly on average pay income taxes at a lower rate because of lower cash incomes.

Despite these differences in tax treatment, consideration of tax payments does not appear to have a substantial effect on the relative economic status of the elderly. Because the tax burden of the elderly tends to be light, there is little difference between the distributions of their pretax and posttax cash incomes. While the somewhat heavier tax burden of the nonelderly does result in lower posttax incomes, the difference does not appear to be substantial. In 1980, only 42 percent of the elderly had pretax incomes above $10,000, compared to only 43 percent with posttax incomes above this amount. At the same time, 75 percent of the nonelderly had pretax incomes in excess of $10,000 compared to 69 percent with posttax incomes over this level.

TABLE 1.—PERCENT DISTRIBUTION OF ELDERLY AND NONELDERLY FAMILIES, BY FAMILY INCOME CLASS, USING PRETAX AND POSTTAX INCOME, 1980

| Family income amount | Pretax cash income | | Posttax cash income | |
|---|---|---|---|---|
| | Nonelderly | Elderly | Nonelderly | Elderly |
| Less than $3,000 | 5.9 | 7.1 | 6.2 | 7.1 |
| $3,000 to $5,999 | 7.9 | 27.4 | 9.3 | 27.4 |
| $6,000 to $9,999 | 11.1 | 22.8 | 15.7 | 24.0 |
| $10,000 to $14,999 | 14.8 | 17.2 | 19.2 | 18.2 |
| $15,000 to $19,999 | 14.0 | 9.3 | 17.7 | 10.0 |
| $20,000 to $34,999 | 30.0 | 11.5 | 25.9 | 10.3 |
| $35,000+ | 16.3 | 4.7 | 6.0 | 3.0 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 |

Source: ICF, Inc., Background Data on the Relative Economic Status of the Elderly and Nonelderly in 1980. Prepared for the U.S. Congress, Senate Special Committee on Aging. February 1984.

### (D) IN-KIND BENEFITS

Critics contend that the difference in income between the elderly and nonelderly would be reduced if the analysis of income took into account the value of in-kind transfers. In-kind transfers are of particular significance to the elderly, since nearly every older person is covered by medicare hospital insurance. In addition, 20.4 percent of all elderly households receive at least one means-tested in-kind benefit such as food stamps, publicly owned or subsidized housing, or medicaid.[6]

A Census study of the effect of including in-kind transfers on the 1979 poverty rate concluded that the poverty rate for elderly households, in particular, declined substantially when the value of noncash benefits was included in income. Nearly all of the reduction, however, was attributable to valuing medical and institutional care. Including the value of only food and housing transfers in 1979 money income lowered poverty rates among the elderly from 14.7 to between 12.9 and 13.7 percent, depending on the method of valuation. The addition of medical care, including institutional expenses, lowered poverty rates to between 4.5 and 10.8 percent. A similar revaluation for all poor, including the elderly, had a less significant effect, lowering the overall poverty rate from 11.1 to between 6.4 and 8.9 percent.[7]

---

[6] U.S. Congress. Senate Special Committee on Aging. Developments in Aging: 1982, v. 1. 98th Cong., 1st sess. Washington, U.S. Govt. Print. Off. pt. II, table 3. From a special tabulation of the March 1982 CPS.

TABLE 2.—COMPARISON OF POVERTY RATES USING ALTERNATIVE INCOME CONCEPTS, VALUATION TECHNIQUES, 1979

[In percent]

| Income concept | Valuation technique | | |
|---|---|---|---|
| | Market value | Cash equivalent value | Poverty budget share value |
| Money income alone: | | | |
| Elderly | 14.7 | 14.7 | 14.7 |
| All poor | 11.1 | 11.1 | 11.1 |
| Money income plus food and housing: | | | |
| Elderly | 12.9 | 13.1 | 13.7 |
| All poor | 9.4 | 9.5 | 9.8 |
| Money income plus food, housing, and medical care (excluding institutional care): | | | |
| Elderly | 5.2 | 9.3 | 10.8 |
| All poor | 6.6 | 8.7 | 8.9 |
| Money income plus food, housing, and medical care (including institutional care): | | | |
| Elderly | 4.5 | 8.0 | 10.8 |
| All poor | 6.4 | 8.2 | 8.9 |

Source: U.S. Bureau of the Census. Alternative Methods for Valuing Selected In-Kind Transfer Benefits and Measuring Their Effect on Poverty. Technical paper No. 50. U.S. Govt. Print. Off. 1982.

Including medicare and means-tested in-kind benefits in the income of elderly and nonelderly families causes a more substantial upward shift in the income distribution of the elderly than of the nonelderly. When the value of in-kind benefits is added to income, the proportion of elderly families with incomes in excess of $10,000 increases from 42.7 percent to 46.2 percent, while the proportion of nonelderly families with incomes in excess of $10,000 only increases from 75.1 percent to 76.0 percent.[8] The greater effect of in-kind benefits on elderly income can be attributed largely to the value of medicare coverage, which improves the income of nearly all elderly families. Means-tested in-kind benefits, on the other hand, have little effect on the incomes of middle and upper income families, and only help to reduce the large numbers of elderly and nonelderly clustered at very low income levels.

---

[7] U.S. Dept. of Commerce. Bureau of the Census. Alternative Methods for Valuing Selected In-Kind Transfer Benefits and Measuring Their Effect on Poverty. Technical paper No. 50. Washington, U.S. Govt. Print. Off. 1982. Tables A and B.

[8] Information prepared by ICF, Inc., on the effect of in-kind transfers on 1980 income of the elderly and nonelderly is based on a "cash equivalent" value of benefit to the recipient. This is an estimate of the amount of cash which would have provided the same utility to the recipient as the in-kind benefit received. This method produces a lower value than the cost to the Government of providing the benefit, but a higher value than estimates based on the "poverty shares" method. For details on ICF's methodology see: ICF, Inc., Background Data on the Relative Economic Status of the Elderly and the Non-Elderly in 1980. Prepared for the U.S. Senate Special Committee on Aging, February 1984. Appendix B.

TABLE 3.—PERCENT DISTRIBUTION OF ELDERLY AND NONELDERLY FAMILIES, BY INCOME CLASS, USING PRETAX INCOME WITH AND WITHOUT IN-KIND BENEFITS

| Family income amount | Pretax cash income | | Pretax cash income with in-kind benefits | |
|---|---|---|---|---|
| | Nonelderly | Elderly | Nonelderly | Elderly |
| Less than $3,000 | 5.9 | 7.1 | 4.8 | 3.9 |
| $3,000 to $5,999 | 7.9 | 27.4 | 7.3 | 25.3 |
| $6,000 to $9,999 | 11.1 | 22.8 | 11.9 | 24.6 |
| $10,000 to $14,999 | 14.8 | 17.2 | 15.2 | 18.1 |
| $15,000 to $19,999 | 14.0 | 9.3 | 14.6 | 10.6 |
| $20,000 to $34,999 | 30.0 | 11.5 | 30.2 | 12.3 |
| $35,000+ | 16.3 | 4.7 | 16.5 | 5.2 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 |

Source: ICF, Inc., Background Data on the Relative Economic Status of the Elderly and the Nonelderly in 1980. Prepared for the U.S. Congress, Senate. Special Committee on Aging. February 1984.

While this analysis provides an insight into the effect of in-kind transfers on individual well-being, it provides only a partial, and thus biased, measure of their effect on the relative economic status of the elderly and nonelderly. There is no agreement yet among researchers on how to measure in-kind transfers, and the three alternative measures selected in the Census Bureau study produced widely varying results on net poverty rates of the elderly and nonelderly. More significantly, studies to date have attempted to measure only transfers from means-tested programs which go primarily to the elderly and poor. No comparable work has been done in valuing tax subsidies and employer-provided fringes which go primarily to nonelderly middle and upper income groups. The Census study suggested that of an estimated $216 billion of in-kind income provided publicly and privately in 1980, means-tested transfers accounted for only $48 billion. Non-means-tested in-kind income from tax subsidies and private sources accounted for $113 billion.[9]

It is reasonable to speculate that including the value of noncash transfers across the board would raise the incomes of all income groups, without necessarily affecting the distribution of individuals across groups. Those who now have the lowest money incomes could well remain relatively poor under the new income measures, while the "near poor," who benefit least from means-tested transfers, employer-provided benefits, or tax subsidies, could well decline to the lowest relative income levels under the new measures.

### (E) ASSETS

The elderly as a group hold substantially more in assets than the nonelderly. Because of this difference, some analysts have argued that comparison of only the incomes of the elderly and nonelderly results in a biased assessment of their relative well-being. They argue that the assets of the elderly are available to them for consumption if necessary and should, thus, be considered in comparing their relative economic status.

---

[9] Bureau of the Census. Alternative Methods for Valuing Selected In-Kind Transfer Benefits. Table 2.

The fact that the elderly hold more assets than the nonelderly is the result of normal life-cycle processes. People naturally tend to accumulate savings, home equity, and personal property over a lifetime. A recent study, based on 1973 Treasury Department data, reveals that although the elderly accounted for only 20 percent of the households in 1973, they owned 27 percent of the wealth. The elderly, as a group, had a mean wealth ($50,855) 35 percent greater than the mean wealth of all households ($37,711).[10]

Although the elderly as a group hold greater assets than the nonelderly, the elderly as individuals are less likely than other individuals to hold any assets. In other words, wealth greatly enhances the economic status of some elderly, but is of little or no value to most of the elderly. The distribution of wealth is more unequal among the elderly than among any but the youngest age group. Over one-half of the households with heads 65 and over had no wealth whatsoever in 1973. At the same time, 21 percent of the top wealth holding households were headed by someone 65 or older.[11]

The inclusion of the value of wealth in the comparison of elderly and nonelderly income exaggerates the relative economic well-being of the elderly because of weaknesses in the methodology. First, the wealth of the elderly is primarily home equity. The elderly are more likely to be homeowners with greater equity in their homes than the nonelderly. Over 70 percent of elderly households now live in owner-occupied homes and half of these are owned free and clear. However, home equity is inherently less liquid than most other assets, and may easily appear to have greater value on paper than it has to the individual. Thus, the contribution home equity makes to economic well-being is uncertain—to include it in the comparison of the economic status of the elderly and nonelderly overstates the well-being of the elderly, while to exclude it clearly understates their well-being.

The second problem involves the assumption for converting assets to income. Patterns of dissaving assets do not relate directly to age. Individuals who draw on their assets to meet consumption needs, do so at widely varying rates. Younger people using savings to finance their education or a home purchase may dissave their assets over a few years, while the elderly are likely to draw down their assets over a much longer period. The rates that are assumed in converting assets to income, however, greatly affect the income value of a given set of assets to an elderly or nonelderly individual. Using an age-related rate for annuitizing an asset—as if the individual were purchasing an indexed life annuity—dissaves the assets of the elderly at a more rapid rate than those of the nonelderly—making the income value of a given asset pool much greater for the elderly.

---

[10] Greenwood, Daphne. Age, Income, and Household Size: Their Relation to Wealth Distribution in the United States. A paper presented to the C. V. Starr Center for Applied Economics Conference on International Comparisons of the Distribution of Household Wealth, New York University, Nov. 11-12, 1983. Table 2.

[11] Ibid.

The effect of assets on the relative well-being of the elderly is substantial, though it is exaggerated by available techniques for construing asset value as income. Including the annuity value of nonhousing assets in the incomes of elderly families has its greatest effect on the incomes of those in the middle income ranges, with practically no effect on those with incomes below $10,000.[12] However, including housing in addition to nonhousing assets, has a significant effect on the incomes of elderly in all income categories, reducing the percent of elderly with incomes below $10,000 from 52.7 percent to 42.5 percent.

TABLE 4.—PERCENT DISTRIBUTION OF ELDERLY AND NONELDERLY FAMILIES, BY FAMILY INCOME CLASS, USING POSTTAX CASH INCOME, INCLUDING IN-KIND BENEFITS, HOUSING AND NONHOUSING ASSETS, 1980

| Family income amount | Posttax cash income, including in-kind benefits | | Posttax cash income, including nonhousing assets | | Posttax cash income assets, including housing and nonhousing | |
|---|---|---|---|---|---|---|
| | Nonelderly | Elderly | Nonelderly | Elderly | Nonelderly | Elderly |
| Less than $3,000 | 5.0 | 3.9 | 5.0 | 3.8 | 4.7 | 2.3 |
| $3,000 to $5,999 | 8.7 | 25.4 | 8.7 | 24.1 | 8.3 | 17.5 |
| $6,000 to $9,999 | 16.3 | 25.7 | 16.3 | 24.7 | 15.8 | 22.7 |
| $10,000 to $14,999 | 9.7 | 19.2 | 9.7 | 8.9 | 19.0 | 21.1 |
| $15,000 to $19,999 | 17.9 | 11.1 | 17.9 | 11.9 | 17.5 | 14.3 |
| $20,000 to $34,999 | 26.3 | 11.6 | 26.3 | 13.5 | 27.6 | 16.8 |
| $35,000+ | 6.1 | 3.0 | 6.1 | 4.1 | 7.0 | 5.4 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

Source: ICF, Inc., Background Data on the Relative Economic Status of the Elderly and Nonelderly in 1980. Prepared for the U.S. Congress Senate Special Committee on Aging. February 1984.

While including annuitized wealth in income does narrow the income gap between the elderly and nonelderly, there remains a significant difference between these two groups in the distribution of income. With annuitized housing and nonhousing assets and in-kind benefits included in income, net of tax payments, the elderly are still more likely to be concentrated at low income levels than the nonelderly. After all of these adjustments to income, 42.5 percent of the elderly families had incomes below $10,000 in 1980 compared to only 28.8 percent of the nonelderly families.

### (F) FAMILY SIZE

The smaller size of elderly families has a more significant effect on the relative economic status of the elderly and nonelderly than any of the other factors. Most older people live either alone or with a spouse, while younger families tend to have one or more children living in the household. As a result, the average elderly family size is 1.5 persons compared to 3.4 persons for the average nonelderly family. With smaller families, the elderly do not have to stretch their incomes as far as the nonelderly, leaving more income for each family member.

---

[12] The income value of assets in the 1980 data prepared by ICF, Inc. is based on the higher of either actual income reported from assets in the March 1981 CPS or the annual income which would be derived if the individual used his assets to purchase an indexed life annuity. The annuity value (contribution to annual income) of the asset increases with the age of the purchaser. For details on ICF's methodology see: ICF, Inc. Background Data on the Relative Economic Status of the Elderly and the Non-Elderly in 1980. Prepared for the U.S. Senate Special Committee on Aging, February 1984. Appendix B.

The simplest adjustment for family size is to divide family income by the number of persons in the family—resulting in a per capita income figure. The problem with this approach is that it ignores the economies of scale which are possible in larger households, exaggerating the relative well-being of individuals in smaller households. For example, the housing cost for a fourth person in a family is substantially less than the housing cost for the first person. To compute a simple per capita measure of income assumes that the housing cost for a single person is one-fourth the housing cost for a family of four. The best adjustment for family size is one which accounts for the smaller marginal costs of adding each successive family member. The equivalency scale based on the family size adjustment used in the poverty index is used in the following analysis.

Adjustment of income for family size affects the income distribution of both elderly and nonelderly families, reducing the concentrations of families in the low income categories and increasing the proportion of families appearing in the highest income ranges. The effect is greater for elderly than nonelderly families, reducing the proportion of elderly families with pretax cash incomes below $10,000 from 57.3 percent to 33.2 percent, while the proportion of nonelderly families with incomes below $10,000 is reduced from 24.9 percent to 17.1 percent.

TABLE 5.—PERCENT DISTRIBUTION OF ELDERLY AND NONELDERLY FAMILIES, BY FAMILY INCOME CLASS, USING PRETAX INCOME AND PRETAX INCOME ADJUSTED FOR FAMILY SIZE, 1980

| Family income amount | Pretax cash income | | Pretax cash income, adjusted for family size | |
|---|---|---|---|---|
| | Nonelderly | Elderly | Nonelderly | Elderly |
| Less than $3,000 | 5.9 | 7.1 | 4.0 | 1.4 |
| $3,000 to 5,999 | 7.9 | 27.4 | 5.1 | 8.4 |
| $6,000 to 9,999 | 11.1 | 22.8 | 8.0 | 23.4 |
| $10,000 to 14,999 | 14.8 | 17.2 | 10.7 | 20.1 |
| $15,000 to 19,999 | 14.0 | 9.3 | 12.5 | 14.0 |
| $20,000 to 34,999 | 30.0 | 11.5 | 31.4 | 20.3 |
| $35,000+ | 16.3 | 4.7 | 28.3 | 12.3 |
| Total | 100.0 | 100. | 100.0 | 100.0 |

Source: ICF, Inc., Background Data on the Relative Economic Status of the Elderly and Nonelderly in 1980. Prepared for the U.S. Congress, Senate Special Committee on Aging. February 1984.

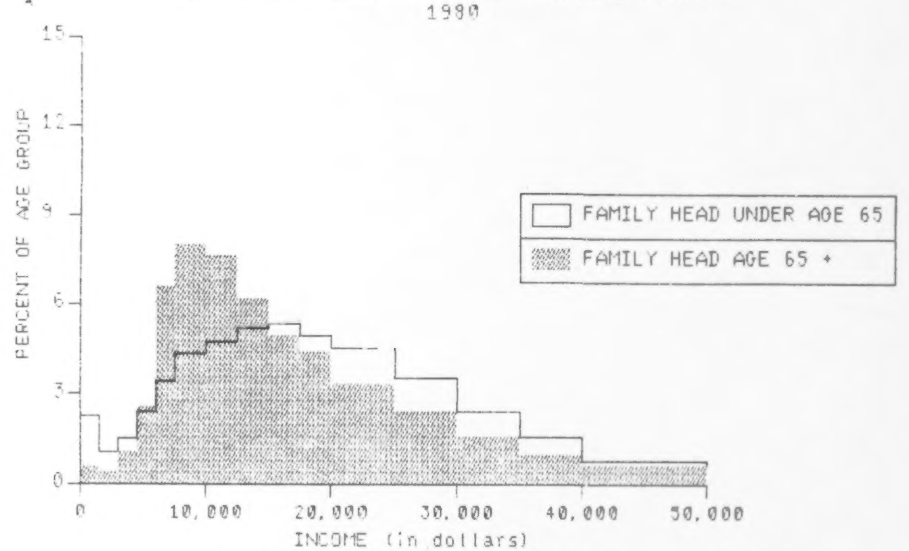
Even controlling for family size, the elderly are significantly more likely to have low incomes than the nonelderly. Twice as large a proportion of elderly families than nonelderly families had family incomes below $10,000, after the adjustment for family size.

### (G) CONCLUSION

In recent years there has been increasing support for the notion that the economic status of the elderly has come to resemble that of the nonelderly. The notion that the elderly have the same resources younger workers have is used as justification for proposing cuts in social security spending or increased shifting of medicare costs to beneficiaries. However, the contention that the elderly are as well off as the nonelderly has been based on simple and often misleading comparisons of average income.

In fact, significantly higher proportions of the elderly than the nonelderly have low cash incomes. Some of the low income concentration among the elderly can be reduced if income is redefined to include in-kind benefits and liquid assets, to factor out tax payments, and to adjust for family size. Similar but less intense changes occur in the income distribution of the nonelderly when these factors are taken into consideration. But even when income is compared net of all of these factors, larger proportions of the elderly than of the nonelderly remain concentrated at low levels of income.

CHART 7



CASH AND IN-KIND AFTER TAX FAMILY INCOME, ADJUSTED FOR FAMILY SIZE
(INCLUDING ANNUITIZED NON-HOUSING ASSETS)
1980

SOURCE: ICF INCORPORATED, "BACKGROUND DATA ON THE RELATIVE ECONOMIC STATUS OF THE ELDERLY AND NON-ELDERLY IN 1980," FEBRUARY 1984

## B. RETIREMENT INCOME—1983

1983 was a year of tremendous change in retirement income programs. After several years of virtual stagnation on retirement issues, the Congress finally enacted legislation to correct financing difficulties in social security and railroad retirement and began seriously considering legislation to strengthen the pension benefit guarantee program and enhance women's pension benefits. The social security financing legislation was particularly noteworthy, first, because it restored a condition of short and long run financial solvency which the program has not experienced in over a decade, and second, because in covering new Federal employees under social security it set in motion a process of restructuring Federal employee pensions.

These positive changes obscured for the moment a growing concern about the burden of public income support for the elderly on younger workers. Though workers' real earnings will rise this year due to recent economic growth, in previous years the real incomes of the nonelderly have declined, while the elderly have maintained their real incomes, largely because of the successful indexing of retirement benefits. This narrowing of the income gap between the elderly and nonelderly has created a sense that the incomes of elderly families have surpassed those of younger families, and this in turn has raised interest in capping spending on entitlements as a means of reducing the budget deficits.

Concern about the growth of entitlement spending in the budget continued in 1983, even though the social security financing package reduced fiscal year 1983-85 budget deficits by $35 billion. Within a month of the enactment of the 1983 Social Security Amendments, a proposal was introduced in the Senate to further reduce annual cost-of-living adjustments in social security to achieve another $25 billion in savings over 3 years. This reduction was to be linked to a comparable increase in income taxes, as part of a "CPI minus 3" solution to soaring budget deficits. At the end of the year, despite the relatively sound financial condition of retirement income programs, policymakers were being driven by high deficits to search for savings in the one-fifth of the Federal budget devoted to providing retirement income for the elderly.

The 98th Congress returned, amidst uncertainty about the budget, to start its second session in the 10th anniversary year of two landmark pieces of income legislation. Both the supplemental security income (SSI) program and the Employee Retirement Income Security Act (ERISA) went into effect in 1974. The first created a Federal income floor for the elderly, and the second established safeguards and guarantees for the private pension benefits of retired workers. These anniversaries afford the Congress the opportunity to review past progress toward providing the elderly adequate income in retirement, and to renew its pledge to achieving this goal for the future.

# Chapter 3

# SOCIAL SECURITY

## OVERVIEW

Congress acted in 1983 to restore financial solvency to the social security program and end 4 years of bitter partisan debate over the future of the program. The Social Security Amendments of 1983, signed by the President as Public Law 98-21 on April 20, 1983, eliminated projected short- and long-term deficits in the retirement, survivors, and disability insurance programs. Congress left unresolved for the moment the future of the medicare program, whose hospital insurance (HI) trust fund faces a far more serious financing deficiency over the remainder of this decade.

The Social Security Amendments of 1983 moved quickly through the legislative process under the threat of imminent delays in issuing social security checks. The 15-member, bipartisan National Commission on Social Security Reform reported a "consensus package" of recommendations to the Congress on January 15, 1983. Hearings on the recommendations before the House Ways and Means Committee began on February 1, and were followed on February 15 by hearings before the Senate Finance Committee. On March 3, the House Ways and Means Committee reported H.R. 1900 to implement the recommendations of the National Commission, which passed the House 6 days later by a vote of 282-148. The Senate Finance Committee marked up its own bill—S. 1, which had been introduced by Senators Dole, Heinz, Moynihan, and others in January—and reported it with committee amendments on March 11. On March 23, the Senate passed these as amendments to H.R. 1900, by a vote of 88-9. Conferees from the House and Senate met to work out a compromise bill on March 24, and on March 25 the conference report was approved in both Houses by wide margins.

The enactment of this legislation was a major milestone in the recent history of social security. For the first time in a decade, there are neither short- nor long-run deficits in the old-age and survivors insurance (OASI) and disability insurance (DI) trust funds. The 1983 amendments improved financing of OASI and DI by $166 billion between 1983 and 1990 and eliminated a projected 75-year deficit of 2.10 percent of taxable payroll.

While the 1983 amendments restore the financial solvency of the social security cash benefit programs under current forecasts, there can be no guarantee that the program will remain solvent in the indefinite future. Deterioration in the economy worse than that already forecast by the social security actuaries could conceivably force the Congress to address another short-term financing problem before the decade is out. In the long run, social security will always be subject to review and modification as the Congress strives to achieve a balance in the program between the interests of those paying taxes and those receiving benefits.

Social security is essentially a political and not a financial institution. As such, the fundamental solvency concern is that the Congress act with unanimity and resolve to correct financing problems when they occur. The most significant achievement of the 1983 amendments was that the Congress acted quickly and decisively to restore solvency in a manner that reaffirmed the existing structure of social security and was generally accepted as reasonable and fair. The bipartisan consensus achieved by the National Commission on Social Security Reform and its rapid enactment by the Congress are likely to become a model for the resolution of medicare's financing crisis and future modifications in the OASDI programs.

## A. BACKGROUND

### 1. Origins of the Social Security Program

The social security program enacted in 1935 was designed to begin as a modest program with a relatively low tax rate and grow in stages until it reached maturity in the 1980's. As its architects anticipated, social security has only recently come of age, with the first generation of lifelong contributors retiring and beginning to draw benefits. While social security has grown and changed tremendously over the course of its development, the basic guiding principles of the old-age pension program have remained unchanged.

Social security was designed as a universal social insurance program with compulsory participation. As such, it was intended to eventually provide all workers and their families with a floor of income protection in the event the worker was no longer able to earn income due to retirement or, later, premature death or disability. This "floor of protection" was to provide only a portion of the income needed by the worker and his family to maintain their previous standard of living. It was intended that workers would supplement this protection with private insurance, savings and investments, and other arrangement made voluntarily by the worker.

In recognition that workers with low earnings would have greater difficulty providing supplementary protection than high earners, the benefits in the program were weighted to give a higher replacement of earnings to lower income individuals. In keeping with the concept of insurance, benefits were to be paid when an insured-against condition or event was determined to have occurred, without regard to whether the individual had other means for support.

Social security was not intended initially to be either an investment program or a welfare program. These functions are performed through other public or private vehicles. The primary function of social security has always been to insure some replacement of earnings when workers are no longer working. As such it also provides income protection through the retirement program to current workers who might otherwise have to financially support older relatives.

Social security provides workers with benefits they have earned. Both the funding for the program and the benefits paid have, therefore, always been "earnings related." Funding comes from earmarked payroll tax "contributions" which are a fixed proportion (6.7 percent in 1983) of each worker's earnings, matched by an equivalent employer's contribution. Social security benefits, then, are based on the average lifetime earnings of the worker.

While architects of the original program foresaw a more complete from of social insurance, the Social Security Act of 1935 established only a Federal old-age insurance program (OAI) with mandatory coverage for workers in commerce and industry. Initially, only 43 percent of the labor force was covered.[1] Employer and employee contributions were each set at 1 percent of the first $3,000 of earnings, with a scheduled increase to 3 percent by 1950. Over the years, this program has been modified to expand coverage, improve the quality of income protection for workers, and increase funding for the program.

### (A) COVERAGE

In an effort to make participation in social security universal, the Congress has, over time, continued to bring additional groups of employees under the system. During the 1950's and 1960's, mandatory coverage was extended to farm and domestic workers, the self-employed, the military, physicians, ministers, and some members of religious orders. Coverage was extended on an elective basis in 1950 and 1954 to employees of nonprofit organizations and State and local government entities. By 1970, virtually all gainfully employed workers, except employees of the Federal Government, and some employees of State and local government and nonprofit organizations, were covered by social security. At the end of 1983, an estimated 115 million workers, or 95 percent of all jobs, were covered by social security.

The 1983 Social Security Amendments extended mandatory coverage still further, leaving only current Federal employees and some State and local government employees outside the system. Effective January 1, 1984, all employees of nonprofit organizations, Members of Congress, the President, Vice President, executive branch employees, Federal judges, and newly hired Federal employees will be covered under social security.

### (B) BENEFITS

The quality of income protection has been improved since the original law was enacted through the addition of new benefits and increases in benefit amounts. The simple program enacted in 1935 to pay retirement annuities to workers in proportion to their career earnings, was never put into effect. A year before the first benefits were paid, the 1939 amendments added survivors insurance and dependents' benefits and changed the benefit formula to provide more adequate benefits to low-income and short-term workers. The change in benefits introduced into social security the principle of greater help for greater presumed need.

---

[1] Social Security Administration. Social Security Bulletin, Annual Statistical Supplement, 1982. Table 4.

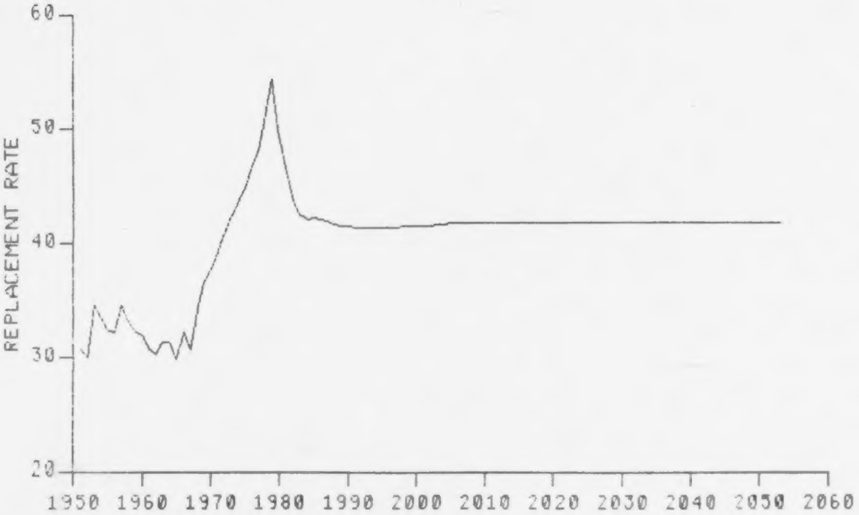
Additional forms of insurance were enacted in the 1950's and 1960's. In 1956, the disability insurance (DI) program was added, providing cash benefits for severely disabled workers, and for adult children of retired workers if disabled before age 18. Dependents' benefits were added to this program in 1958. In 1965, Congress established medicare with two parts: A basic compulsory program for hospital insurance (HI) funded by a separate payroll tax, and a voluntary supplementary medical insurance plan (SMI) to provide coverage for physician expenses, funded jointly through monthly premiums paid by the beneficiary and Federal general revenue appropriations. Medicare was expanded in 1972 by extending coverage to those under 65 entitled to disability cash benefits for 24 consecutive months, and to certain victims of chronic renal disease.

Congress has also sought to maintain the adequacy of benefits over the lifetime of beneficiaries by granting periodic increases in benefits to keep up with inflation. Prior to 1975, every cost-of-living adjustment was legislated separately, frequently increasing benefits by more than the rate of inflation. Between 1968 and 1971, the Congress enacted across-the-board benefit increases of 43 percent, while consumer prices rose by only 27 percent. In the 1972 amendments, the Congress enacted an additional benefit increase of 20 percent. However, at the same time Congress enacted an automatic annual adjustment for increases in the Consumer Price Index (CPI) of 3 percent or more, effective in 1975, to eliminate the need for ad hoc increases. It was widely believed at the time that the automatic indexing of benefits would result in lower benefit increases than those granted on an ad hoc basis. Nevertheless, rapid price increases in the late 1970's caused another 40 percent increase in benefits between 1978 and 1981.

1972 also saw a change in the method of computing the workers average earnings and the basic benefit amount so that initial benefits would rise with the standard of living over time. A technical error in the indexing method led Congress to enact another change in the computation formula in 1977 which had the effect of fixing the relationship between initial benefits and earnings over time. The legislation also set long-run relative benefit levels below levels which would have resulted from earlier legislation. As a result of the 1977 amendments, social security benefits over the long run are expected to replace about 42 percent of the average worker's preretirement earnings, compared to replacement rates for the average worker under prior law which were projected to reach 56 percent. The revised indexing of initial benefits enacted in 1977 is expected to maintain a stable 42 percent replacement rate for the average worker in the future.

## CHART 1

SOCIAL SECURITY:
AVERAGE REPLACEMENT RATES, ACTUAL AND ESTIMATED
1953-2055



SOURCE: Social Security Administration, "Historical Replacement for Steady Workers" and "Projection of Replacement Rates for Steady Workers" June, 1981

### (C) TAXES

Financing for the program has also changed over the years. The collection of payroll taxes to finance the old-age insurance program began in 1937 under the provisions of the Federal Insurance Contributions Act (FICA). To minimize the shock, initial tax rates were low and were scheduled to increase gradually. The tax in the first year was 1 percent on the first $3,000 of a worker's earnings with a matching tax on the employer. The original act included a schedule of increases in the tax rate of 0.5 percent every 3 years, leading to a maximum rate of 3 percent on employer and employee each by 1949. However, during World War II, the scheduled increases were deferred, and it was not until 1950 that the tax rate was finally increased to 1.5 percent. The old-age and survivors insurance tax rate did not reach the originally scheduled maximum of 3 percent until 1963.

TABLE 1.—OASI TAX RATES ORIGINALLY PROPOSED AND ACTUAL, 1937 to 1980

| Year | Rate scheduled in 1937 act | Actual rate |
|---|---|---|
| 1937 | 1.0 | 1.0 |
| 1940 | 1.5 | 1.0 |
| 1945 | 2.5 | 1.0 |
| 1950 | 3.0 | 1.5 |
| 1955 | 3.0 | 2.0 |
| 1960 | 3.0 | 2.75 |
| 1965 | 3.0 | 3.375 |
| 1970 | 3.0 | 3.65 |
| 1975 | 3.0 | 4.375 |
| 1980 | 3.0 | 4.52 |

In 1951, the earnings base was increased for the first time to $3,600, and a tax rate of 2.25 percent was assessed on the self-employed, under the provisions of the Self-Employment Contributions Act (SECA), as they entered the system. Since then, the tax rate and earnings base have been increased to keep pace with improvements in the program. Disability insurance was enacted in 1956, with its own tax of 0.25 percent each on employer and employee. Hospital insurance (medicare—part A) was enacted in 1965, with its own tax of 0.35 percent, scheduled to increase to 0.8 percent by 1987.

The combined OASDHI tax rate has been raised several times since 1965. The tax rate which applied in 1983, established in the 1977 amendments, was set at 6.7 percent on employees and employers, and 9.35 percent on the self-employed. The 1983 amendments raised tax rates scheduled for 1984 to 1989, but did not change the ultimate rate of 7.65 on employer and employee, scheduled to take effect in 1990. The 1983 amendment also initiated a gradually increasing tax rate on self-employment income which is intended to approximate the tax treatment of wage and salary income by 1990. For 1984, the tax rate on employer and employee each is 7 percent, with a 0.3 percent temporary tax credit for employees making the effective tax rate on employees 6.7 percent for 1984 only. The tax rate on self-employment income is 14 percent in 1984, with an offsetting tax credit to reduce the effective rate to 11.3 percent.

The 1977 amendments also indexed the taxable earnings base to increases in covered wages. The first automatic increase went into effect in 1982, raising the amount of taxable earnings to $32,400. Rising tax rates and taxable earnings amounts have raised the maximum amount of annual taxes paid by employees from $30 in 1937, to $2,646 in 1984.

## TABLE 2.—MAXIMUM CONTRIBUTION AND CUMULATIVE SOCIAL SECURITY EMPLOYMENT TAXES PAID BY EMPLOYEE

| Year | Tax rate percent | Maximum wages taxable | Maximum annual tax contribution | Taxes paid cumulative total |
|---|---|---|---|---|
| 1937 | 1.0 | $3,000 | $30.00 | $30.00 |
| 1938 | 1.0 | 3,000 | 30.00 | 60.00 |
| 1939 | 1.0 | 3,000 | 30.00 | 90.00 |
| 1940 | 1.0 | 3,000 | 30.00 | 120.00 |
| 1941 | 1.0 | 3,000 | 30.00 | 150.00 |
| 1942 | 1.0 | 3,000 | 30.00 | 180.00 |
| 1943 | 1.0 | 3,000 | 30.00 | 210.00 |
| 1944 | 1.0 | 3,000 | 30.00 | 240.00 |
| 1945 | 1.0 | 3,000 | 30.00 | 270.00 |
| 1946 | 1.0 | 3,000 | 30.00 | 300.00 |
| 1947 | 1.0 | 3,000 | 30.00 | 330.00 |
| 1948 | 1.0 | 3,000 | 30.00 | 360.00 |
| 1949 | 1.0 | 3,000 | 30.00 | 390.00 |
| 1950 | 1.5 | 3,000 | 45.00 | 435.00 |
| 1951 | 1.5 | 3,600 | 54.00 | 489.00 |
| 1952 | 1.5 | 3,600 | 54.00 | 543.00 |
| 1953 | 1.5 | 3,600 | 54.00 | 597.00 |
| 1954 | 2.0 | 3,600 | 72.00 | 669.00 |
| 1955 | 2.0 | 4,200 | 84.00 | 753.00 |
| 1956 | 2.0 | 4,200 | 84.00 | 837.00 |
| 1957 | 2.25 | 4,200 | 94.50 | 931.50 |
| 1958 | 2.25 | 4,200 | 94.50 | 1,026.00 |
| 1959 | 2.5 | 4,800 | 120.00 | 1,146.00 |
| 1960 | 3.0 | 4,800 | 144.00 | 1,290.00 |
| 1961 | 3.0 | 4,800 | 144.00 | 1,434.00 |
| 1962 | 3.125 | 4,800 | 150.00 | 1,584.00 |
| 1963 | 3.625 | 4,800 | 174.00 | 1,758.00 |
| 1964 | 3.625 | 4,800 | 174.00 | 1,932.00 |
| 1965 | 3.625 | 4,800 | 174.00 | 2,106.00 |
| 1966 | 4.2 | 6,600 | 277.20 | 2,383.20 |
| 1967 | 4.4 | 6,600 | 290.40 | 2,673.60 |
| 1968 | 4.4 | 7,800 | 343.20 | 3,016.80 |
| 1969 | 4.8 | 7,800 | 374.40 | 3,391.20 |
| 1970 | 4.8 | 7,800 | 374.40 | 3,765.60 |
| 1971 | 5.2 | 7,800 | 405.60 | 4,171.20 |
| 1972 | 5.2 | 9,000 | 468.00 | 4,639.20 |
| 1973 | 5.85 | 10,800 | 631.80 | 5,271.00 |
| 1974 | 5.85 | 13,200 | 772.20 | 6,043.20 |
| 1975 | 5.85 | 14,100 | 824.85 | 6,868.05 |
| 1976 | 5.85 | 15,300 | 895.05 | 7,763.10 |
| 1977 | 5.85 | 16,500 | 965.25 | 8,728.35 |
| 1978 | 6.05 | 17,700 | 1,070.85 | 9,799.20 |
| 1979 | 6.13 | 22,900 | 1,403.77 | 11,202.97 |
| 1980 | 6.13 | 25,900 | 1,587.67 | 12,790.64 |
| 1981 | 6.55 | 29,700 | 1,975.05 | 14,765.69 |
| 1982 | 6.70 | 32,400 | 2,170.80 | 16,936.49 |
| 1983 | 6.70 | 35,700 | 2,391.90 | 19,328.39 |
| 1984 | [1] 7.00 | 37,800 | 2,646.00 | 21,974.39 |

[1] The effective tax rate for the employee is 6.7 percent in 1984 due to a 0.3 percent income tax credit applied at the time of withholding.

## B. FINANCING PROBLEMS

### 1. FINANCING IN THE 1970's

As recently as 1970, the old-age, survivors, and disability insurance (OASDI) trust funds had on hand a reserve equal to 1 year's payout, an amount then considered adequate to meet any changes in expenditures or income due to unforeseen economic fluctuations. When Congress passed the 1972 amendments to the Social Security Act, economic forecasts projected a continuation of the relatively high growth rates and the low rates of inflation which had been experienced during the 1960's. Under these conditions, social security revenues would have adequately covered payouts, and trust fund reserves would have remained sufficient for contingencies.

The 1972 amendments increased social security benefits across the board by 20 percent, and initiated the price indexing of benefits, and a complex indexing method for computing the initial benefit. A technical error in the method of computing the initial benefit led to an "over-indexing" of initial benefit amounts for new beneficiaries. In addition, when price indexing of benefits went into effect in 1975, annual inflation rates of around 10 percent began to fuel a rapid increase in payouts from the system. A recession in 1974–75 raised unemployment rates to their highest level since World War II, and slowed the growth in real wages, causing income to the OASDI program to fall below expenditures. Finally, disability insurance trust funds were being steadily eroded because of a continuing rapid increase in beneficiaries.

Beginning in 1973, the board of trustees of the OASDI program began to predict a deterioration in the financial condition of the program in both the immediate future and over the long run. By 1977, the trustees predicted that the DI trust funds would be depleted by 1979, and the OASI trust funds by 1983. The long-run deficit (75-year average) was predicted to reach 8.20 percent of taxable payroll, a dramatic increase from the 0.32-percent average deficit predicted in the 1973 report. By 1977, reserves in the OASDI trust funds had already declined to less than 6 months' payout.

Congress moved in 1977 to correct the financial condition of the OASDI program. The 1977 amendments to the Social Security Act increased the overall payroll tax beginning in 1979, increased the taxable earnings base, reallocated a portion of the hospital insurance (HI) payroll tax rate to OASI and DI, and resolved the technical problems in the method of computing the initial benefit amount (decoupling). These changes were predicted to produce surpluses in the OASDI program beginning in 1980, and continuing over the next 30 years, with reserves building up to 7 months' payout by 1987. The long-run deficit in the OASDI program was to have been reduced from an average 8.2 percent to 1.46 percent of taxable payroll.

Again, however, the economy did not perform as well as forecasts had predicted. After 1979, annual increases in the Consumer Price Index exceeded 10 percent, a rate sufficient to double payouts from the program in just 7 years. Real wage changes have been negative or near zero since 1977, and in 1980, unemployment rates exceeded 7 percent. As a result, annual income to the OASDI program continued to be insufficient to cover expenditures. Trust fund balances declined from $36 billion in 1977, to $26 billion in 1980. Lower trust fund balances, combined with rapidly increasing expenditures, brought reserves down to less than 3 months' payout by 1980.

The 96th Congress responded by temporarily reallocating a portion of the DI tax rate to OASDI for 1980 and 1981. This measure (signed into law as Public Law 96–403) was intended to buy time for the 97th Congress to resolve the shortage of funds in the OASI and DI programs.

### 2. THE 97TH CONGRESS

The 97th Congress moved quickly to address the impending financial shortfall in social security, but quickly encountered the political realities of this issue. Congressional concern about the financing problem had been mounting throughout 1980, and in February 1981, the House Ways and Means Committee began considering comprehensive financing legislation. Simultaneously, proposals to eliminate social security student benefits and minimum benefits were successfully incorporated into the fiscal year 1982 budget legislation.

But the climate for social security reform soon changed. In May, the administration's announcement of a comprehensive social security reform package with immediate benefit reductions touched off an adverse political reaction in the Congress. Enactment of the Omnibus Budget Reconciliation Act of 1981, eliminating the minimum benefit, only added to the controversy. By midsummer there was general disagreement over even the dimensions of the social security financing problems. When the Congress enacted the Social Security Amendments of 1981 to restore the minimum benefit for current beneficiaries, they included a provision authorizing the OASI trust fund to borrow sufficient funds from the DI and HI trust funds to last through July 1983. These amendments, however, were the last piece of financing legislation considered in the 97th Congress.

At the end of 1981, in an effort to break the political impasse, the President appointed a 15-member, bipartisan, National Commission on Social Security Reform to search for a politically feasible solution to social security's financing problem. The Commission was given a year to develop a consensus approach to financing the system.

Meanwhile, the condition of the social security trust funds worsened. By the end of 1981, OASDI reserves had declined to $24.5 billion, an amount sufficient to pay benefits for only 1½ months. Even though falling inflation rates were helping to keep outgo below projected levels, still-sluggish wage growth and rising unemployment kept income to the system below the level needed to cover outgo. Legislative changes included in the Omnibus Budget Reconciliation Act of 1981 and the Social Security Amendments of 1981 were expected to improve the financial condition of the OASDI trust funds by $2.8 billion in calendar year 1982 alone, and by $21.7 billion between 1981 and 1986. But the 1982 trustees report projected that any financial gains from the 1981 legislation would be totally offset by continuing stagnation in the economy.

By November 1982, the OASI trust fund had exhausted its cashable reserves, and in November and December was forced to borrow $17.5 billion from DI and HI trust fund reserves to finance benefit payments through July 1983.

The delay imposed by the work of the National Commission deferred the legislative solution to social security's financing problems to the 98th Congress. But the Commission did provide clear guidance to the new Congress on the exact dimensions of the various financing problems in social security, and on a politically viable package of solutions.

### 3. IMPROVEMENT OF THE TRUST FUNDS—1983

Based on the recommendations of the National Commission, the Congress enacted changes in 1983 in the old-age, survivors, and disability insurance (OASDI) program to correct the short-term deficit and restore long-term solvency under current assumptions. Neither the National Commission nor the Congress, however, sought to correct the even more serious financing problems in medicare's hospital insurance (HI) trust fund.

#### (A) OASDI—SHORT-TERM FINANCING

The fund with the most immediate financing need in early 1983 was the old-age and survivors insurance (OASI) trust fund. At the end of October 1982, the OASI trust fund had a balance of $10 billion, almost $1 billion less than was needed to make the November benefit payments. A loan of $0.6 billion from the DI trust fund in November, and an additional $16.9 billion from DI and HI in December, enablied OASI to meet benefit payments through June 1983.

The disability insurance (DI) trust fund was somewhat more sound, but its surpluses were overshadowed by the immensity of the projected deficits in OASI. The existing DI tax rate coupled with the effect of improvements in actual disability experience was maintaining a positive cash flow in this program. At the end of October 1982, the DI trust fund had a balance of $6.9 billion, but this reserve was largely depleted by the $5.1 billion loan to OASI.

As a result of the $12.4 billion loan from HI, the OASDI combined trust funds had a 15-percent ratio of reserves to projected 1983 outgo, as of January 1, 1983. Preliminary estimates for the 1983 report of the trustees showed that, without legislation, the OASDI trust funds were expected to experience deficits averaging about $21 billion a year between 1983 and 1989 under intermediate assumptions, and $25 billion a year prior to 1985, increasing to $51 billion by 1989 under pessimistic assumptions.[2] Because intermediate forecasts have proven to be more optimistic than actual experience in recent years, there was general support in the National Commission for basing policy decisions on pessimistic assumptions, or on intermediate assumptions with higher reserve ratios.

The National Commission on Social Security Reform adopted this approach in its recommendation that between 1983 and 1989, the Congress improve the financial condition of the trust funds by $150 to $200 billion. Added revenues or savings of this amount would enable OASDI to maintain the minimum safe reserve margin of 15 percent under somewhat pessimistic assumptions or to build up a somewhat safer reserve margin should economic performance prove to be better.

---

[2] Social Security Administration. Office of the Actuary. Memorandum of Feb. 7, 1983, based on assumptions prepared for use in the 1983 trustees report. Tables 2 and 3.

The changes enacted by the Congress are expected to improve the financial condition of the trust funds by $166 billion between 1983 and 1989, and maintain, under intermediate assumptions, barely sufficient reserves throughout. The 1983 amendments called for the immediate transfer of $20.2 billion from the general fund to OASDI in May to offset the expected 1983 deficit. Most of the transfer ($19.7 billion) was made as a reimbursement for gratuitous wage credits previously granted by social security for military service. The remaining $500 million was a reimbursement from the Treasury for the amount of outstanding uncashed social security checks.

TABLE 3.—ESTIMATED CHANGES IN OASDI TAX INCOME, GENERAL FUND TRANSFERS, AND BENEFIT PAYMENTS RESULTING FROM PROVISIONS IN PUBLIC LAW 98–21, UNDER 1983 ALTERNATIVE II–B ASSUMPTIONS, CALENDAR YEARS 1983–89

[In billions of dollars]

| Provision | Calendar year— | | | | | | | Total |
|---|---|---|---|---|---|---|---|---|
| | 1983 | 1984 | 1985 | 1986 | 1987 | 1988 | 1989 | |
| Total for all changes | 22.8 | 19.2 | 13.9 | 15.3 | 18.0 | 35.8 | 41.2 | 166.2 |
| Increase tax rate on covered wages and salaries | | 8.6 | 0.3 | | | 14.5 | 16.0 | 39.4 |
| Increase tax rate on covered self-employment earnings | | 1.1 | 3.1 | 3.0 | 3.2 | 3.7 | 4.4 | 18.5 |
| Total for new coverage | | 1.5 | 2.2 | 3.0 | 3.9 | 5.0 | 6.1 | 21.8 |
| Cover all Federal elected officials and political appointees | | (1) | (1) | (1) | (1) | (1) | (1) | .1 |
| Cover new Federal employees | | .2 | .7 | 1.2 | 1.8 | 2.4 | 3.1 | 9.3 |
| Cover all nonprofit employees | | 1.3 | 1.5 | 1.8 | 2.1 | 2.6 | 3.0 | 12.4 |
| Prohibit State and local government terminations | | .1 | .2 | .4 | .6 | .8 | 1.1 | 3.2 |
| Accelerate collection of State and local taxes | | .6 | (1) | (1) | .1 | .1 | .1 | 1.0 |
| Modify general fund reimbursement methods for military service credits | 18.4 | −.4 | −.4 | −.3 | −.4 | −.4 | −.4 | 16.1 |
| Provide general fund transfers for unnegotiated checks | 1.3 | .1 | .1 | .1 | .1 | .1 | .1 | 1.6 |
| Delay benefit increases 6 months | 3.2 | 5.2 | 5.4 | 5.5 | 6.2 | 6.7 | 7.3 | 39.4 |
| Limit benefit increases to lesser of wage or price increase, under certain conditions | | | (2) | (2) | (2) | (2) | (2) | (2) |
| Continue benefits on remarriage | | (3) | (3) | (3) | (3) | (3) | (3) | −.1 |
| Modify indexing of deferred survivor benefits | | | (3) | (3) | (3) | (3) | (3) | (3) |
| Raise disabled widow(er)'s benefits to 71.5 percent of PIA | | −.2 | −.2 | −.2 | −.2 | −.3 | −.3 | −1.4 |
| Pay divorced spouses whether or not worker has retired | | | (3) | (3) | (3) | (3) | (3) | −.1 |
| Replace 90-percent factor in benefit formula with variable percentage, for individuals receiving pensions from noncovered employment | | | | (4) | (4) | (4) | .1 | .1 |
| Offset spouses' benefits by up to two-thirds of noncovered government pension | (3) | (3) | (3) | (3) | (3) | (3) | (3) | (3) |
| Expand use of death certificates to stop benefits | (4) | (4) | (4) | (4) | (4) | (4) | (4) | .1 |
| Impose 5-year residency requirement for certain aliens | | | (4) | (4) | (4) | (4) | (4) | .1 |
| Tax one-half of benefits for high-income beneficiaries | | 2.6 | 3.2 | 3.9 | 4.7 | 5.6 | 6.7 | 26.6 |
| All other miscellaneous and technical changes | (3) | (3) | (3) | (3) | (3) | (3) | (3) | −.1 |

[1] Net additional taxes of less than $50 million.

[2] Although it is not expected that this provision would "trigger" (that is, actually take effect) under the Alternative II–B assumptions, relatively small variation from these assumptions could cause it to trigger. Under Alternative III assumptions it would take effect with respect to the benefit increases for December 1984 and December 1985.

[3] Additional benefits of less than $50 million.

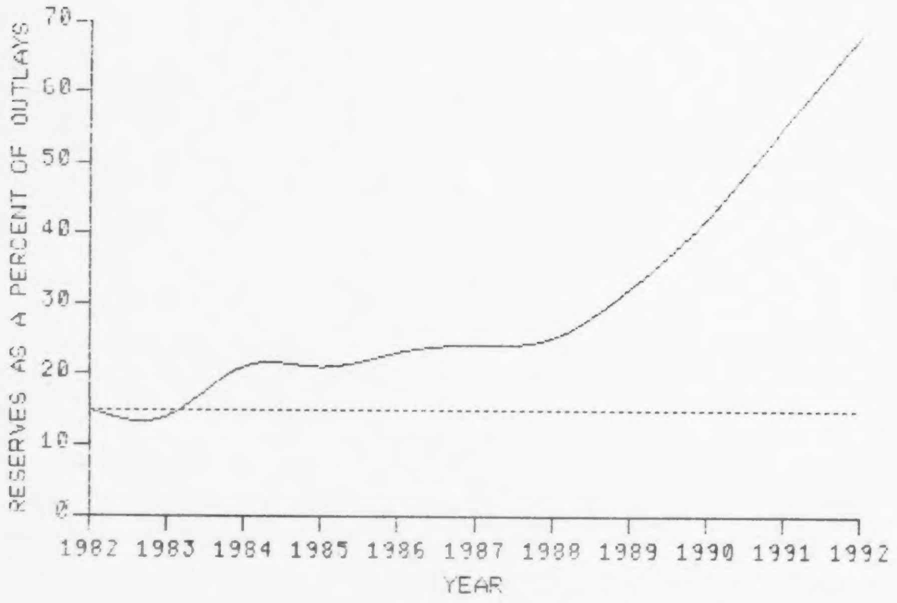
[4] Reduction in benefits of less than $50 million.

Note: Estimates shown for each provision include the effects of interaction with all preceding provisions. Totals do not always equal the sum of components due to rounding. Positive figures represent additional income or reductions in benefits. Negative figures represent reductions in income or increases in benefits.

Source: Svahn, John A. and Mary Ross. Social Security Amendments of 1983: Legislative History and Summary of Provisions. Social Security Bulletin, v. 46, July 1983. Table 1.

The OASDI reserves were also bolstered through an immediate change in Treasury procedure for transferring monthly tax revenues to social security. In the past, transfers of monthly tax revenues had been made throughout the month within a few days of their receipt by the Treasury. Under this system, because monthly social security checks are debited at the beginning of the month, the trust funds were required to have reserves at least equal to a full month's payments on hand at the beginning of each month. As a result of the 1983 Social Security Amendments, effective May 1, the Treasury at the beginning of each month is now transferring to social security an amount equal to the estimated receipts for that month, before the month's payments are debited.

CHART 2


OASDI TRUST FUNDS
ESTIMATED RATIO OF RESERVES TO OUTLAYS
CALENDAR YEARS 1982-1992

SOURCE: SOCIAL SECURITY ADMINISTRATION, OFFICE OF THE ACTUARY: MEMORANDUM, NOVEMBER 16, 1983

As a result of the 1983 amendments, OASDI trust fund reserves are expected, based on the 1983 trustees report intermediate assumptions revised in November 1983, to increase from a low of 14 percent of expected annual outgo at the beginning of 1983 to 21 percent at the beginning of 1984. Thereafter, reserve ratios are expected to rise steadily, reaching 68 percent of expected outgo by the beginning of 1992. These reserves should be sufficient to continue uninterrupted benefit payments throughout the decade, and make required repayments of loans to the HI trust funds.

TABLE 4.—ESTIMATED OPERATIONS OF THE OASI AND DI TRUST FUNDS UNDER PRESENT LAW ON THE BASIS OF THE REVISED 1983 TRUSTEES REPORT ALTERNATIVE II–B ASSUMPTIONS, CALENDAR YEARS 1982–92

[Amounts in billions]

| Calendar year | Income | | | Outgo | | | Interfund borrowing transfers [1] | |
|---|---|---|---|---|---|---|---|---|
| | OASI | DI | OASDI | OASI | DI | OASDI | OASI | DI |
| 1982 | $125.2 | $22.7 | $147.9 | $142.1 | $18.0 | $160.1 | $17.5 | –$5.1 |
| 1983 | 150.6 | 20.7 | 171.3 | 152.8 | 18.2 | 171.0 | | |
| 1984 | 166.7 | 17.2 | 183.9 | 163.2 | 18.6 | 181.8 | | |
| 1985 | 185.3 | 18.6 | 203.9 | 178.2 | 19.6 | 197.8 | | |
| 1986 | 201.2 | 20.0 | 221.2 | 193.5 | 20.7 | 214.1 | –1.2 | |
| 1987 | 217.3 | 21.5 | 238.8 | 208.4 | 21.7 | 230.0 | –4.7 | |
| 1988 | 248.0 | 24.2 | 272.3 | 223.3 | 22.9 | 246.2 | –6.5 | |
| 1989 | 268.1 | 26.0 | 294.1 | 238.1 | 24.1 | 262.3 | –5.1 | 5.1 |
| 1990 | 292.1 | 31.2 | 323.2 | 253.5 | 25.6 | 279.1 | | |
| 1991 | 312.7 | 33.6 | 346.4 | 269.7 | 27.2 | 296.9 | | |
| 1992 | 334.8 | 36.1 | 370.9 | 286.6 | 28.9 | 315.6 | | |

| Calendar year | Net increase in funds | | | Funds at end of year | | | Assets at beginning of year as a percentge of outgo during year [2] | | |
|---|---|---|---|---|---|---|---|---|---|
| | OASI | DI | OASDI | OASDI | DI | OASDI | OASI | DI | OASDI |
| 1982 | $0.6 | –$0.4 | $0.2 | $22.1 | $2.7 | $24.8 | 15 | 17 | 15 |
| 1983 | –2.2 | 2.5 | .3 | 19.9 | 5.1 | 25.1 | 14 | 15 | 14 |
| 1984 | 3.4 | –1.3 | 2.1 | 23.3 | 3.8 | 27.1 | 19 | 34 | 21 |
| 1985 | 7.1 | –.9 | 6.1 | 30.4 | 2.9 | 33.2 | 20 | 26 | 21 |
| 1986 | 6.5 | –.6 | 5.9 | 36.9 | 2.2 | 39.1 | 23 | 20 | 23 |
| 1987 | 4.3 | –.2 | 4.1 | 41.2 | 2.0 | 43.2 | 25 | 17 | 24 |
| 1988 | 18.2 | 1.4 | 19.6 | 59.3 | 3.4 | 62.8 | 26 | 16 | 25 |
| 1989 | 24.9 | 6.9 | 31.8 | 84.2 | 10.3 | 94.6 | 33 | 21 | 32 |
| 1990 | 38.6 | 5.6 | 44.1 | 122.8 | 15.9 | 138.7 | 41 | 49 | 42 |
| 1991 | 43.0 | 6.5 | 49.5 | 165.8 | 22.3 | 188.2 | 53 | 67 | 55 |
| 1992 | 48.2 | 7.2 | 55.4 | 214.1 | 29.5 | 243.6 | 66 | 86 | 68 |

[1] Positive figures represent amounts borrowed by the trust fund or recoveries of prior loans to other trust funds; negative figures represent amounts loaned by the trust fund or repayments of prior loans from other trust funds.

[2] Assets at beginning of year are defined for the OASI and DI Trust Funds as assets at end of prior year plus the respective OASI and DI advance tax transfers for January.

Source: Social Security Administration. Office of the Actuary. Memorandum of Nov. 16, 1983. Table 2.

To protect trust fund reserves from the effects of unanticipated fluctuations in the economy, the Congress also enacted a "stabilizer" proposal to reduce annual cost-of-living adjustments (COLA's) when reserves are low. Despite the adequacy of projected reserves, there is a chance that the COLA "stabilizer" could go into effect as early as 1985.

Under the "stabilizer" provision, annual COLA's are to be based on the lesser of the wage increase or the price increase whenever reserves drop below 15 percent (20 percent after 1987). However, the "reserve ratio" used to trigger the "stabilizer" is computed quite differently than the normal reserve ratio used in assessing the status of the trust funds. Under the "stabilizer" computation, OASDI trust fund reserves are projected to barely exceed the 15 percent trigger in 1984 and to fall below the 15 percent trigger in 1985. Should the 1984 reserve ratio actually drop below 15 percent, it is possible that a reduced COLA could be paid in January 1985, since the CPI increase is currently projected to exceed the wage increase by 1.5 percent.[3]

### (B) MEDICARE FINANCING PROBLEMS

Early in the debate in the 97th Congress on the short-term OASDI financing problem, the financing problem in the hospital insurance (HI) trust fund was generally viewed as a concern for the next decade. The HI trust fund was seen as a source of funds to aid the ailing OASDI trust funds until the 1990 tax increase went into effect. However, in the last 2 years the forecasts for the HI trust fund have grown significantly worse. It is now anticipated that absent a change in the law, the HI trust fund will exhaust its reserves in 1990 without any prospect of recovery.

The future deficits in the HI program are a result of forecasts of continuing high growth rates in hospital costs exceeding the growth rate in the CPI. In recent years, hospital costs have increased at an annual rate in excess of 15 percent, nearly double the rate of CPI increase. While under Intermediate II-B assumptions used in the 1983 trustees report, rates of hospital cost increases are projected to decline from 13.2 percent in 1983, to 8.6 percent in

TABLE 5.—ESTIMATED CHANGES IN HI TAX INCOME, GENERAL FUND TRANSFERS, OR BENEFIT OUTGO, UNDER PUBLIC LAW 98–21, BASED ON 1983 ALTERNATIVE II–B ASSUMPTIONS

[In billions of dollars]

| Provision | Calendar year— | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | 1983 | 1984 | 1985 | 1986 | 1987 | 1988 | 1989 | Total |
| Total for HI changes | 3.3 | 0.8 | 1.9 | 4.1 | 5.9 | 7.8 | 9.8 | 33.6 |
| Provide for prospective hospital reimbursement [1] | | | .2 | 2.0 | 3.6 | 5.2 | 7.0 | 18.0 |
| Delay single reimbursement rate for nursing facilities | (2) | (2) | | | | | | (2) |
| Reduce allowable return on equity | (3) | .1 | .1 | .1 | .1 | .1 | .2 | .7 |
| Increase tax rate on covered self-employment earnings | | .4 | 1.3 | 1.5 | 1.6 | 1.7 | 1.8 | 8.3 |
| Cover all Federal elected officials and political appointees | | (4) | (4) | (4) | (4) | (4) | (4) | (4) |
| Cover all nonprofit employees | | .3 | .4 | .5 | .5 | .6 | .7 | 3.0 |
| Prohibit State and local government terminations | | (4) | .1 | .1 | .1 | .2 | .3 | .8 |
| Accelerate collection of State and local taxes | | .2 | (4) | (4) | (4) | (4) | (4) | .2 |
| Modify general fund reimbursement methods for military service credits | 3.3 | −.1 | −.1 | −.1 | −.1 | −.1 | −.1 | 2.5 |

[1] Savings attributable to prospective payments were computed as the additional savings that would be generated in fiscal year 1986 and later by eliminating the October 1985 sunset provision on the hospital rate-of-increase-limits of section 101(b) of the Tax Equity and Fiscal Responsibility Act. The prospective payment legislation as passed by Congress does not mandate a system that would necessarily generate this level of savings. Instead, the level of prospective payment rates is left to the discretion of the Secretary of HHS.

[2] Additional benefits of less than $50 million.

[3] Reduction in provider reimbursement of less than $50 million.

[4] Net additional tax income of less than $50 million.

Note: Estimates shown for each provision include the effects of interaction with all preceding provisions. Totals do not always equal the sum of components due to rounding. Positive figures represent additional income or reductions in benefits. Negative figures represent reductions in income or increases in benefits.

Source: Svahn, John A. and Mary Ross. Social Security Amendments of 1983: Legislative History and Summary of Provisions. Social Security Bulletin, v. 46, July 1983. Table 6.

---

[3] Social Security Administration. Office of the Actuary. Memorandum of Nov. 16, 1983, based on revised 1983 trustees report assumptions. Table 2.

2005, these rates of increase are expected to remain more than twice the rate of increase projected for the CPI.[4]

In the short term, medicare is expected to experience small annual deficits, maintaining sufficient reserves throughout 1989. At the beginning of 1983, the HI fund had $8.2 billion in reserves, roughly 20 percent of the estimated outgo for the HI program. Reserves were this low largely as a result of the $12.4 billion transfer to OASI in December 1982. The prognosis for the HI trust fund was substantially improved in 1983 as a result of changes in medicare reimbursement and taxes enacted in the Social Security Amendments of 1983, which are expected to improve the short-term financing of medicare by an estimated $33.6 billion between 1983 and 1989. These changes supplemented medicare savings enacted in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA).

TABLE 6.—ESTIMATED OPERATIONS OF THE HOSPITAL INSURANCE TRUST FUND DURING CALENDAR YEARS 1982–96, UNDER ALTERNATIVE II–B (INTERMEDIATE) ASSUMPTIONS

[Dollar amounts in billions]

| Calendar year | Total income | Total disbursements | Interfund borrowing transfers[1] | Net increase in fund | Fund at end of year | Ratio of assets to disbursements (percent)[2] |
|---|---|---|---|---|---|---|
| 1982[3] | 38.8 | 36.1 | −12.4 | −10.6 | 8.2 | 52 |
| 1983 | 44.7 | 41.2 | | 3.5 | 11.7 | 20 |
| 1984 | 45.6 | 46.6 | .5 | −.5 | 11.2 | 25 |
| 1985 | 51.3 | 52.3 | | −1.0 | 10.2 | 21 |
| 1986 | 58.4 | 58.0 | 1.1 | 1.5 | 11.8 | 18 |
| 1987 | 62.5 | 64.1 | 2.4 | .8 | 12.6 | 18 |
| 1988 | 66.0 | 71.0 | 8.4 | 3.5 | 16.1 | 18 |
| 1989 | 70.0 | 78.4 | | − 8.4 | 7.8 | 21 |
| 1990 | 73.9 | 86.6 | | −12.6 | ([4]) | 9 |

[1] A loan to the OASI trust fund would still be an asset of the HI trust fund. However, since these assets are not immediately available for payment of HI benefits, they are subtracted from the HI fund balance. A negative amount is a loan to the OASI trust fund. A positive amount is a repayment of principal to the HI trust fund.

[2] Ratio of assets in the trust fund at the beginning of the year to disbursements during the year.

[3] Figures for 1982 represent actual experience.

[4] Trust fund depleted in calendar year 1990.

Note: Totals do not necessarily equal the sum of rounded components.

Source: 1983 Report of the Trustees of the Federal Hospital Insurance Trust Fund. Table 10.

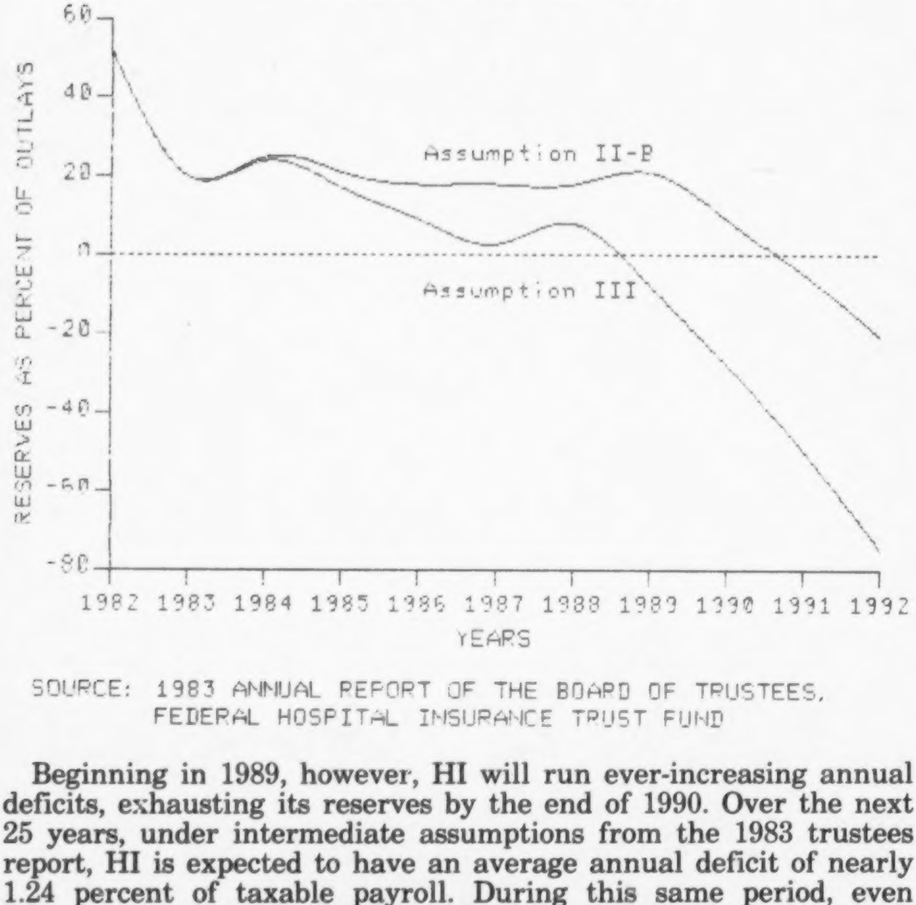
Under intermediate assumptions from the 1983 trustees report, HI is expected to maintain reserves equal to about 20 percent of annual outgo through 1988. By the end of 1988, HI is expected to have a reserve on hand of $16.1 billion, 21 percent of the estimated payout for 1989.

---

[4] 1983 annual report of the Board of Trustees of the Federal Hospital Insurance Trust Fund. Table A1.

CHART 3

HOSPITAL INSURANCE TRUST FUND
ESTIMATED RATIO OF RESERVES TO OUTLAYS
CALENDAR YEARS 1982-1992



SOURCE: 1983 ANNUAL REPORT OF THE BOARD OF TRUSTEES,
FEDERAL HOSPITAL INSURANCE TRUST FUND

Beginning in 1989, however, HI will run ever-increasing annual deficits, exhausting its reserves by the end of 1990. Over the next 25 years, under intermediate assumptions from the 1983 trustees report, HI is expected to have an average annual deficit of nearly 1.24 percent of taxable payroll. During this same period, even before the enactment of the 1983 amendments, OASDI was expected to experience an average annual surplus of 0.58 percent of taxable under intermediate assumptions.[5]

### (C) THE LONG-TERM OASDI PROBLEM

The OASDI trust fund is expected to experience a favorable financial period over the next 25 years, followed by a gradual deterioration of the trust funds beginning around 2015 as the "baby boom" generation begins to retire. After 2030, the condition of the trust fund should stabilize, leaving large annual deficits through the remaining 30 years of the projections. Under 1983 trustees' report intermediate assumptions, OASDI is expected to have sufficient funds to meet its benefit as a result of the 1983 amendments.

---

[5] Ibid., table 11.

## TABLE 7.—ESTIMATED LONG-RANGE OASDI COST EFFECT OF THE SOCIAL SECURITY AMENDMENTS OF 1983

| Section | Provision | Effect as percent of payroll | | |
|---|---|---|---|---|
| | | OASI | DI | OASDI |
| | Prior Law: | | | |
| | Average cost rate | 13.04 | 1.34 | 14.38 |
| | Average tax rate | 10.13 | 2.17 | 12.29 |
| | Actuarial balance | −2.92 | +.83 | −2.09 |
| | Changes included in titles I and III of the amendments: [1] | | | |
| 101 | Cover new Federal employees | +.26 | +.02 | +.28 |
| 102 | Cover all nonprofit employees | +.09 | +.01 | +.10 |
| 103 | Prohibit State and local terminations | +.06 | +.00 | +.06 |
| 111 | Delay benefit increases 6 months | +.28 | +.03 | +.30 |
| 112 | Stabilize trust fund ratio | | | |
| 113 | Eliminate "windfall" benefits | +.04 | +.00 | +.04 |
| 114 | Raise delayed retirement credits | −.10 | | −.10 |
| 121 | Tax one-half of benefits | +.56 | +.05 | +.61 |
| 123 | Accelerate tax rate increase | +.03 | | +.03 |
| 124 | Increase tax rate on self-employment | +.17 | +.02 | +.19 |
| 124 | Adjust self-employment income | −.02 | −.00 | −.03 |
| 126 | Change DI rate allocation | +.81 | −.81 | |
| 131 | Continue benefits on remarriage | −.00 | −.00 | −.00 |
| 132 | Pay divorced spouse of nonretired | −.01 | −.00 | −.01 |
| 133 | Modify indexing of survivor's benefits | −.05 | | −.05 |
| 134 | Raise disabled widow's benefits | −.01 | | −.01 |
| 151 | Modify military credits financing | +.01 | +.00 | +.01 |
| 152 | Credit unnegotiated checks | +.00 | +.00 | +.00 |
| 324 | Tax certain salary reduction plans | +.03 | +.00 | +.03 |
| 337 | Modify public pension offset | −.00 | −.00 | −.00 |
| 340 | Suspend auxiliary benefits for certain aliens | +.00 | +.00 | +.00 |
| 348 | Modify earnings test for those aged 65 and over [2] | −.01 | | −.01 |
| | All other provisions of titles I and III | −.00 | −.00 | −.00 |
| | Subtotal for the effect of the above provisions [3] | +2.07 | −.68 | +1.38 |
| | Remaining deficit after the above provisions | −.85 | +.15 | −.71 |
| | Additional change relating to long-term financing (title II of the amendments): [4] | | | |
| | Raise normal retirement age to 67 | +.83 | −.12 | +.71 |
| | Total effect of all of the provisions [5] | +2.89 | −.80 | +2.09 |
| | After the amendments: | | | |
| | Actuarial balance | −.03 | +.03 | −.00 |
| | Average income rate | 11.47 | 1.42 | 12.89 |
| | Average cost rate | 11.50 | 1.39 | 12.89 |

[1] The values for each of the individual provisions listed from title I and title III represent the effect over present law and do not take into account interaction with other provisions with the exception of section 348.

[2] Estimates for modifying the earnings test take into account interaction with section 114, which raises delayed retirement credits.

[3] The values in the subtotal for all provisions included in title I and title III take into account the estimated interactions among these provisions.

[4] The values for each of the provisions of title II take into account interaction with the provisions included in title I and title III.

[5] The values for the total effect of the amendments take into account interactions among all of the provisions.

Note: The above estimates are based on preliminary 1983 Trustees' Report Alternative II–B assumptions. Individual estimates may not add to totals due to rounding and/or interaction among proposals.

Source: Svahn, John A. and Mary Ross. Social Security Amendments of 1983: Legislative History and Summary of Provisions. Social Security Bulletin, v. 46, July 1983. Table 4.

Prior to the enactment of the 1983 amendments, expenditures were expected to exceed revenues over the next 75 years by an amount equal to an average of 2.10 percent of the annual payroll subject to the social security taxes. This meant that if payroll taxes had been increased to entirely offset this deficit, the average combined OASDI tax rate would have been raised from 12.29 (as scheduled prior to the amendments) to 14.39 percent.

## TABLE 8.—COMPARISON OF ESTIMATED COST RATES AND INCOME RATES OF THE OASDI PROGRAM UNDER ALTERNATIVE II-B, CALENDAR YEARS 1983–2060

[As a percentage of taxable payroll]

| Calendar year | Cost rate | | | Income rate | | | Balance |
|---|---|---|---|---|---|---|---|
| | OASI | DI | Total | Payroll tax | Taxation of benefits | Total | |
| 1983 | 10.28 | 1.21 | 11.49 | 10.80 | [1] 0.44 | 11.24 | −0.24 |
| 1984 | 10.30 | 1.14 | 11.44 | 11.40 | .17 | 11.57 | .12 |
| 1985 | 10.24 | 1.09 | 11.33 | 11.40 | .18 | 11.58 | .25 |
| 1986 | 10.34 | 1.07 | 11.40 | 11.40 | .20 | 11.60 | .20 |
| 1987 | 10.35 | 1.04 | 11.39 | 11.40 | .23 | 11.63 | .24 |
| 1988 | 10.35 | 1.02 | 11.37 | 12.12 | .25 | 12.37 | 1.00 |
| 1989 | 10.29 | 1.01 | 11.30 | 12.12 | .28 | 12.40 | 1.09 |
| 1990 | 10.26 | 1.01 | 11.27 | 12.40 | .31 | 12.71 | 1.44 |
| 1991 | 10.18 | 1.00 | 11.19 | 12.40 | .34 | 12.74 | 1.55 |
| 1992 | 10.10 | 1.00 | 11.10 | 12.40 | .37 | 12.77 | 1.67 |
| 1993 | 9.94 | .99 | 10.93 | 12.40 | .38 | 12.78 | 1.85 |
| 1994 | 9.81 | .98 | 10.79 | 12.40 | .39 | 12.79 | 2.00 |
| 1995 | 9.68 | .97 | 10.65 | 12.40 | .39 | 12.79 | 2.14 |
| 1996 | 9.54 | .97 | 10.51 | 12.40 | .39 | 12.79 | 2.28 |
| 1997 | 9.40 | .96 | 10.36 | 12.40 | .39 | 12.79 | 2.42 |
| 1998 | 9.29 | .98 | 10.27 | 12.40 | .39 | 12.79 | 2.52 |
| 1999 | 9.17 | 1.00 | 10.17 | 12.40 | .38 | 12.78 | 2.62 |
| 2000 | 9.06 | 1.02 | 10.08 | 12.40 | .38 | 12.78 | 2.71 |
| 2001 | 8.96 | 1.05 | 10.01 | 12.40 | .38 | 12.78 | 2.78 |
| 2002 | 8.88 | 1.07 | 9.95 | 12.40 | .38 | 12.78 | 2.83 |
| 2003 | 8.81 | 1.11 | 9.92 | 12.40 | .39 | 12.79 | 2.87 |
| 2004 | 8.75 | 1.14 | 9.90 | 12.40 | .39 | 12.79 | 2.89 |
| 2005 | 8.72 | 1.18 | 9.90 | 12.40 | .39 | 12.79 | 2.89 |
| 2006 | 8.71 | 1.22 | 9.93 | 12.40 | .39 | 12.79 | 2.87 |
| 2007 | 8.73 | 1.26 | 9.98 | 12.40 | .40 | 12.80 | 2.81 |
| 2010 | 8.95 | 1.37 | 10.31 | 12.40 | .42 | 12.82 | 2.51 |
| 2015 | 9.93 | 1.49 | 11.43 | 12.40 | .48 | 12.88 | 1.45 |
| 2020 | 11.21 | 1.55 | 12.76 | 12.40 | .55 | 12.95 | .19 |
| 2025 | 12.40 | 1.56 | 13.96 | 12.40 | .63 | 13.03 | −.93 |
| 2030 | 13.22 | 1.51 | 14.73 | 12.40 | .68 | 13.08 | −1.65 |
| 2035 | 13.62 | 1.53 | 15.16 | 12.40 | .72 | 13.12 | −2.04 |
| 2040 | 13.60 | 1.57 | 15.17 | 12.40 | .74 | 13.14 | −2.03 |
| 2045 | 13.56 | 1.61 | 15.17 | 12.40 | .76 | 13.16 | −2.01 |
| 2050 | 13.66 | 1.61 | 15.27 | 12.40 | .76 | 13.16 | −2.11 |
| 2055 | 13.79 | 1.60 | 15.40 | 12.40 | .77 | 13.17 | −2.23 |
| 2060 | 13.85 | 1.59 | 15.44 | 12.40 | .77 | 13.17 | −2.27 |
| 25-year averages: | | | | | | | |
| 1983–2007 | 9.61 | 1.06 | 10.66 | 12.15 | .34 | 12.50 | 1.83 |
| 2008–2032 | 11.14 | 1.49 | 12.64 | 12.40 | .55 | 12.95 | .32 |
| 2033–2057 | 13.65 | 1.58 | 15.23 | 12.40 | .75 | 13.15 | −2.08 |
| 75-year average: | | | | | | | |
| 1983–2057 | 11.46 | 1.38 | 12.84 | 12.32 | .55 | 12.87 | .02 |

[1] This figure represents the amount, expressed as a percentage of taxable payroll, transferred in 1983 from the general fund of the Treasury to the OASI and DI Trust Funds on account of military service wage credits attributable to service before 1957.

Note: The definitions of alternatives II–A and II–B, the income rates, cost rate, balance, and taxable payroll are presented in the text.

Source: 1983 Report of the Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds. Table 27.

Although the 1983 amendments have eliminated the average deficit over the next 75 years, the status of the trust funds in each of the three 25-year periods between 1983 and 2057 is expected to vary considerably. In the first 25-year period (1983–2007), the trust funds will have an annual surplus of revenues equal to 1.83 percent of taxable payroll. As a result of these surpluses, OASDI reserves are expected to build to more than 200 percent of annual outgo by 1999.

In the second 25-year period (2008–32), the financial condition of OASDI is expected to continue improving in the early years, but begin deteriorating toward the end of the period. Trust fund reserves will grow to over 500 percent of annual expenditures by 2015, and then decline, reaching 437 percent of outgo by 2030. The average surplus during this period will be only 0.32 percent of taxable payroll.

The third 25-year period (2033–57) will be one of continuous deficits. Program costs will grow until 2035 and level off, remaining above annual revenues. By the end of this period, continuing deficits are expected to have depleted the trust funds. Annual deficits over the 25-year period are expected to average 2.08 percent of taxable payroll.

TABLE 9.—ESTIMATED TRUST FUND RATIOS ALTERNATIVE II–B, CALENDAR YEARS 1983–2060

| Calendar year | OASI | DI | Total |
|---|---|---|---|
| 1983 | 15 | 15 | 15 |
| 1984 | 20 | 38 | 22 |
| 1985 | 20 | 32 | 21 |
| 1986 | 22 | 29 | 23 |
| 1987 | 23 | 28 | 23 |
| 1988 | 23 | 30 | 24 |
| 1989 | 28 | 38 | 29 |
| 1990 | 35 | 69 | 38 |
| 1991 | 47 | 89 | 51 |
| 1992 | 59 | 111 | 64 |
| 1993 | 75 | 136 | 80 |
| 1994 | 91 | 161 | 98 |
| 1995 | 110 | 186 | 117 |
| 1996 | 130 | 213 | 137 |
| 1997 | 152 | 240 | 160 |
| 1998 | 175 | 262 | 183 |
| 1999 | 200 | 280 | 208 |
| 2000 | 227 | 297 | 234 |
| 2001 | 253 | 329 | 261 |
| 2002 | 281 | 357 | 289 |
| 2003 | 309 | 379 | 317 |
| 2004 | 338 | 396 | 345 |
| 2005 | 367 | 409 | 372 |
| 2006 | 397 | 419 | 399 |
| 2007 | 425 | 425 | 425 |
| 2010 | 501 | 431 | 491 |
| 2015 | 563 | 421 | 544 |
| 2020 | 556 | 405 | 538 |
| 2025 | 507 | 390 | 494 |
| 2030 | 442 | 393 | 437 |
| 2035 | 372 | 388 | 374 |
| 2040 | 308 | 369 | 314 |
| 2045 | 245 | 339 | 255 |
| 2050 | 178 | 311 | 192 |
| 2055 | 106 | 284 | 125 |
| 2060 | 31 | 260 | 54 |

Source: 1983 Report of the Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds. Table 32.

The long-run financial strain on social security is expected to result from the problems of financing the needs of an expanding older population on an eroding tax base. The first part of this problem is that there are expected to be proportionately more older people, living longer, and continuing to retire early.

Unusually high birth rates after World War II have already created a bulge in the population—the baby boom generation—which is expected to reach retirement age beginning in 30 years. If life expectancy continues to rise and fertility rates stay low, the relative size of this cohort will be even greater by then.

Future life expectancy gains are projected to be substantial. For men age 65, life expectancy has increased by 2 years since 1940 and is expected, under intermediate assumptions, to increase by another 3 years by 2040. For women age 65, life expectancy has increased by 5 years since 1940, and is expected to increase by another 4 years before 2040.[6]

In addition, low rates of fertility may well keep the younger working population relatively small in the future. Fertility rates of 3 to 3.6 children per 1,000 women resulted in the baby boom in the 1950's and early 1960's. Fertility rates then declined precipitously to 1.8 in the late 1970's and early 1980's—rates below the population replacement rate of 2.1 (the rate which will keep the population the same size with no change in immigration rates). Under intermediate assumptions in the 1982 trustees report, fertility rates are expected to rise slowly, reaching the ultimate rate of only 2 in 2007.[7]

These factors will cause the relative size of the older population to rise substantially. The ratio of older persons (age 65 and over) to the "working age population" (age 20 to 64) has grown from roughly 1 to 6 in 1960, to 1 to 5 in 1980, and is estimated to rise to 1 to 3 before 2025.[8]

If these changes are coupled with a continuation of current patterns of early retirement, the relative size of the beneficiary population will grow substantially. The long-term trend has been for fewer people to continue working beyond age 65. Although roughly one out of four persons age 65 and over was working in 1954, only one out of eight did so in 1980. The tendency has been particularly strong among male workers—two out of five men age 65 and over worked in 1954, compared to one out of five in 1980.

The same tendency toward reduced labor-force participation is evident among the 60 to 64 age group, although here, the reduced labor-force participation of men has been offset somewhat by the increased labor-force participation of women. Total labor-force participation of men and women in the 60 to 64 age bracket declined from 55 percent in 1954, to 45 percent in 1980. Male labor-force participation declined from 84 to 61 percent, while labor-force participation of women increased from 27 to 33 percent.[9]

These changes combined are expected to result in more elderly people remaining in beneficiary status for a longer time, thus adding to social security costs, while low birth rates will keep the size of the taxpaying working age group from increasing as rapidly as the beneficiaries. Whereas there are 3.2 covered workers for every OASDI beneficiary today, there are expected to be two covered workers for every one OASDI beneficiary in the year 2035.[10]

---

[6] 1983. Reports of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds. Table 11.

[7] Ibid., table 11.

[8] Ibid., table A1.

[9] U.S. Dept. of Labor. Bureau of Labor Statistics. Unpublished tabulations.

[10] 1983 OASDI Trustees Report. Table 28.

This relative increase in the number of beneficiaries will not necessarily be a problem. Even though there are expected to be fewer workers supporting each beneficiary in 50 years, this added cost per worker will be offset through the increased productivity of the future worker, if productivity gains compare to those experienced over the past 30 years.

While the absolute cost of funding the current structure of benefits in social security is expected to increase substantially over the next 75 years, due to expected increases in the beneficiary-worker ratio, the cost of social security relative to the economy as a whole will not necessarily increase greatly over levels experienced in the 1970's. Currently, social security accounts for 4.8 percent of the GNP. Under intermediate II–B assumptions (with 1.5 percent real wage growth), social security is expected to rise to 6 percent of GNP by 2035, declining to 5.6 percent by 2060.[11]

However, this relative increase in the number of beneficiaries will be a problem if productivity increases do not occur or the social security tax base is allowed to erode—as it is now projected to. The second part of the long-run problem is that social security is expected to be taxing less and less of the compensation paid to workers in the future. Intermediate II–B assumptions for social security financing assume in the long run that the proportion of compensation paid to employees as nontaxable fringe benefits will grow at a rate of 0.3 percent per year—0.1 percent below the average annual rate of growth experienced over the last 30 years. In 1950, fringes accounted for only 5 percent of total compensation, and FICA taxes were levied on 95 percent of compensation. By 1980, fringe benefits had grown to account for 16 percent of compensation, leaving only 84 percent to be taxed for social security. Continuation in this rate of growth in fringe benefits, as projected by the social security actuaries, will result in nontaxable fringes in 2060 accounting for 34 percent of compensation, leaving only 66 percent to be taxed for social security.[12]

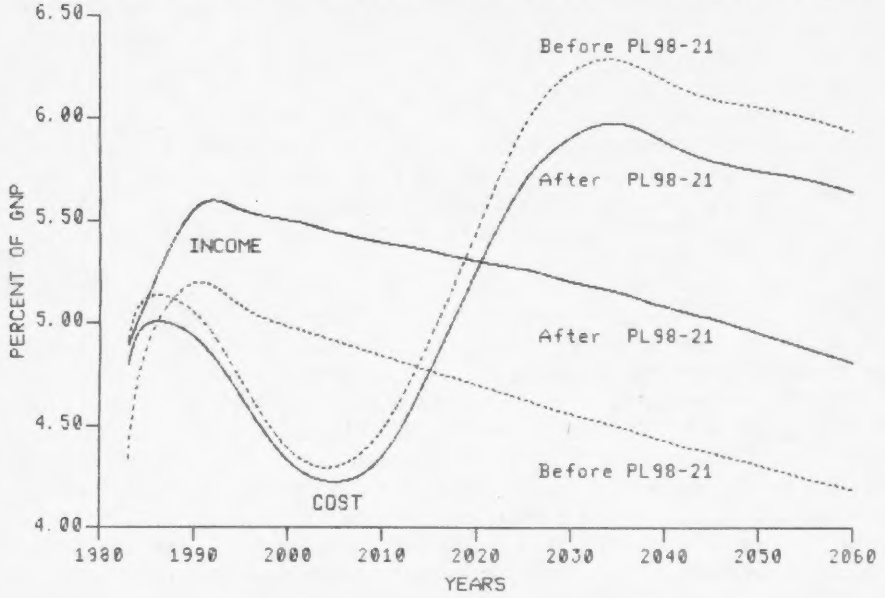
---

[11] Social Security Administration. Office of the Actuary. Memorandum of Jan. 17, 1984, based on 1983 trustees report assumptions.

[12] Social Security Administration. Office of the Actuary. Unpublished tabulations. 1983.

CHART 4

OASDI COST AND INCOME, AS A PERCENTAGE OF GNP
BEFORE AND AFTER THE SOCIAL SECURITY AMENDMENTS OF 1983 (P.L. 98-21)



SOURCE: SOCIAL SECURITY ADMINISTRATION, OFFICE OF
THE ACTUARY: MEMORANDUM, JANUARY 17, 1984

If this potential growth in fringe benefits does occur, it will cause a substantial reduction in the relative value of the social security tax base. Under intermediate II-B assumptions, social security revenues are expected to decline from a high in 1990 of 5.6 percent of GNP, to 4.8 percent of GNP by 2060.[13] Income from the taxation of social security benefits will offset only part of this shrinkage, providing revenues growing from 0.1 percent of GNP in 1990 to 0.4 percent of GNP by 2060.[14]

## C. THE SOCIAL SECURITY AMENDMENTS OF 1983

Once the National Commission on Social Security Reform reached agreement on its recommendations, the Congress moved at a record pace to enact legislation to restore financial solvency in the OASDI trust funds. On January 20, the National Commission transmitted recommendations for changes in OASDI to resolve the short-term financing problem and to eliminate two-thirds of the projected 75-year deficit. Five days later the Commission's recommendations were introduced in the Senate as S. 1 by Senators Dole, Heinz, Moynihan, and others; and within 60 days, the Congress completed action on the legislation. On April 20, only 3 months after the Commission reported its recommendations to the Congress, the President signed the Social Security Amendments of 1983 into law as Public Law 98-21.

---

[13] Social Security Administration Actuary. Jan. 17, 1984. Memorandum.
[14] Social Security Administration Actuary. Unpublished tabulations.

Sections of the 1983 amendments affecting the financing of the OASDI trust funds embodied the recommendations made by the National Commission. The Congress appended additional sections changing hospital reimbursement in medicare, extending supplemental unemployment compensation benefits, and making a number of technical corrections in social security. However, the major purpose of the act was to restore financial solvency in OASDI for the remainder of the decade and over the 75-year long-run forecast period. The final legislation enacted by the Congress improved financing by $166 billion between 1983 and 1989, and eliminated all of what had been reestimated to be a 2.10 percent of payroll 75-year deficit.

The underlying principle of the Commission's bipartisan agreement and the 1983 amendments was to share the immediate cost of refinancing social security equitably between workers, social security beneficiaries, and transfers from other Federal budget accounts. The Commission's recommendations split the near-term costs roughly into thirds: 32 percent of the cost was to come from workers and employers, 38 percent was to come from beneficiaries, and 30 percent was to come from other budget accounts (including contributions from new Federal employees).

The timing of the changes was a second critical feature of the proposals. The OASDI trust funds were expected to be depleted by July 1983, as soon as the amount previously borrowed from HI had been spent. In order to meet immediate revenue needs in 1983 without substantial midyear tax increases or benefit cuts, the Congress authorized an immediate lump-sum transfer of general funds to the OASDI trust funds (actually amounting to $20.2 billion) to compensate for contributions not previously made for past military wage credits and to reimburse for unnegotiated social security checks. Delay of the COLA scheduled to be paid in July was expected to save an additional $3.3 billion in the first year. Although 1984 payroll taxes on employers were to be raised slightly, substantial payroll tax increases involving employers and employees were deferred until 1988, to avoid increasing labor costs during the economic recovery. Between 1984 and 1987, most of the deficit reduction was to be accomplished through the permanent delay in the COLA and the taxation of social security benefits.

The long-run proposals, however, placed almost all of the costs on future beneficiaries. Nearly 80 percent of the long-run financing deficit is reduced through the taxation of benefits, the COLA delay, and the increase in the normal retirement age. The only other proposal significantly reducing the long-run deficit was the extension of mandatory social security coverage to new Federal employees and employees of nonprofit organizations.

The major changes in the OASDI program resulting from the 1983 Social Security Amendments were in the areas of coverage, the tax treatment and annual adjustment of benefits, and payroll tax rates. In addition to these changes, the Congress authorized immediate lump-sum transfers, and enacted several other provisions to safeguard the trust funds and restore public confidence in the program.

## 1. COVERAGE

The 1983 amendments produced the first major expansion of mandatory social security coverage in more than 20 years. Prior to the enactment of these amendments, about 5 percent of all jobs remained outside of social security coverage—mostly jobs in the public sector. Federal employees were completely excluded from coverage by law. State and local government employees and employees of nonprofit organizations were covered if their employers had elected to cover them. As of 1983, 70 percent of all State and local government employees and about 85 percent of the nonprofit employees were covered under social security on a voluntary basis. However, coverage of these employees had been declining in recent years because increasing numbers of State and local government entities and nonprofit employers were exercising their one-time option to terminate social security coverage.

The expansion of coverage was motivated partly by a desire to stabilize the social security tax base and eliminate tax inequities and partly by a concern that inconsistencies in coverage unfairly advantaged some employees and deprived others of an adequate retirement income. Some individuals who spend large portions of their careers in employment not covered by social security unintentionally receive bonuses in their social security benefits. These bonuses or "windfall benefits" result because social security averages the zero earnings from periods of uncovered employment with earnings from covered employment, causing workers with long periods of uncovered employment to receive the higher proportional benefits usually paid only to low-earnings workers. On the other hand, those who work short periods in noncovered employment generally experience gaps in insurance protection and may also lose pension benefits when they change employers.

The 1983 amendments resolved some of the coverage problems by expanding mandatory coverage, preventing further terminations of coverage, and eliminating inequities resulting from incomplete coverage.

### (A) MANDATORY COVERAGE

Congress, in the 1983 amendments, extended coverage as far as it was considered practical. Current Members of Congress, the President, Vice President, executive branch political appointees, sitting Federal judges, congressional employees not participating in the civil service retirement system, and all Federal employees hired after 1983 are covered under social security effective January 1, 1984. All employees of nonprofit organizations are also covered on a mandatory basis January 1, 1984.

### (B) TERMINATION OF COVERAGE

State and local government entities and nonprofit organizations which had not completely terminated coverage by April 20, 1983, are permanently barred from leaving the system. State and local government entities which had previously terminated coverage were allowed a one-time election to rejoin.

### (C) WINDFALL BENEFITS

Congress modified the social security benefit formula, for workers with periods of noncovered employment retiring in the future, to eliminate the "windfall" portion of the benefit. The change will be phased in for workers becoming eligible for benefits between 1985 and 1990. The revised benefit formula will apply fully only to workers with minimal social security coverage. In no case will a worker lose an amount exceeding half of their pension from noncovered employment. Individuals brought under social security as a result of the 1983 amendments will not be affected.

### (D) GOVERNMENT PENSION OFFSET

The reduction in the benefits of spouses and surviving spouses who themselves receive a public pension from noncovered employment is lessened for spouses who become eligible for their pensions after June 1983. The dollar-for-dollar offset enacted in 1977 was criticized because it reduced the spouse's benefit by the entire public pension amount when only part of the pension was analagous to social security. Under the new provision only two-thirds of the public pension will be considered in reducing social security benefits.

## 2. PAYROLL TAXES

The Congress avoided raising payroll tax rates above rates already scheduled in the law. Instead, the previous schedule of tax rate increases leading up to 1990 was accelerated. In addition, the Congress established uniformity in social security tax rates by revising the tax treatment of self-employment income to approximate the current tax treatment of wages and salaries. Previously, self-employment income was taxed at 70 percent of the combined rate on wages and salaries, compensating for the fact that the self-employed could not deduct a portion of the social security tax payment as a business expense. The change in tax treatment is intended to offset increased social security tax payments with reduced income tax payments.

The 1983 amendments also expanded the definition of wages subject to social security taxes to include elective pension contributions made through salary reduction arrangements. This change plus the expansion of coverage were intended to eliminate tax inequities which could lead to erosion in the social security tax base.

### (A) EMPLOYER-EMPLOYEE TAX RATE

The OASDHI tax rate increase of 0.3 percent each on employer and employee, previously scheduled for 1985, was moved up to January 1, 1984. For the employee, the increase is offset with a tax credit applied when taxes are withheld, resulting in no effective increase for the employee. Additionally, a portion of the scheduled 1990 tax increase—0.36 percent each on employer and employee—was moved up to 1988. As a result of these changes, payroll taxes are higher than previously scheduled for employers in 1984, and for employees and employers in 1988 and 1989. Under the new schedule, the combined OASDHI tax rate is 14 percent in 1984 (effectively 13.7 percent), 14.1 percent in 1985, 14.3 percent in 1986 and 1987, 15.02 percent in 1988 and 1989, 15.3 percent in 1990 and thereafter.

TABLE 10.—SOCIAL SECURITY TAX RATES AS A PERCENT OF EARNINGS FOR EMPLOYERS AND EMPLOYEES (EACH) AND FOR THE SELF-EMPLOYED UNDER PUBLIC LAW 98–21

| Year | Employer and employee rates | | | | | Self-employed rates | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | OASI | DI | OASDI | HI | OASDHI | OASI | DI | OASDI | HI | OASDHI |
| Public Law 98–21: | | | | | | | | | | |
| 1983 | 4.775 | 0.625 | 5.4 | 1.3 | 6.7 | 7.1125 | 0.9375 | 8.05 | 1.3 | 9.35 |
| 1984 | 5.2 | .5 | 5.7 | 1.3 | 7.0 | 10.4 | 1.0 | 11.4 | 2.6 | 14.0 |
| 1985 | 5.2 | .5 | 5.7 | 1.35 | 7.05 | 10.4 | 1.0 | 11.4 | 2.7 | 14.1 |
| 1986–87 | 5.2 | .5 | 5.7 | 1.45 | 7.15 | 10.4 | 1.0 | 11.4 | 2.9 | 14.3 |
| 1988–89 | 5.53 | .53 | 6.06 | 1.45 | 7.51 | 11.06 | 1.06 | 12.12 | 2.9 | 15.02 |
| 1990–99 | 5.60 | .6 | 6.2 | 1.45 | 7.65 | 11.20 | 1.2 | 12.4 | 2.9 | 15.3 |
| 2000 and later | 5.49 | .71 | 6.2 | 1.45 | 7.65 | 10.98 | 1.42 | 12.4 | 2.9 | 15.3 |

Source: Svahn, John A. and Mary Ross. Social Security Amendments of 1983: Legislative History and Summary of Provisions. Social Security Bulletin, v. 46, July 1983. Table A.

### (B) SELF-EMPLOYMENT TAX RATE

The 1983 amendments revised the tax treatment of self-employment income, effective in 1990, to correspond to the current treatment of wages and salaries. In the interim, the Congress scheduled an increase in the self-employment tax rate, partially offset by a tax credit, so that the effective tax on self-employment income will rise gradually over the rest of the decade.

Beginning in 1984, the OASDHI tax rate on self-employment income will be equal to the combined rate for employers and employees. This tax increase will be partially offset by a declining tax credit, designed to cushion the immediate effect of the increase. As a result, the effective tax rate on self-employment income will increase from 9.35 percent in 1983 to 11.3 percent in 1984, 11.8 percent in 1985, 12.3 percent in 1986, and 13.02 percent in 1988.

In 1990, the tax treatment of self-employment income will be revised to conform to the tax treatment of wage and salary income. The OASDHI tax rate on self-employment income will be the same 15.3 percent rate applied to other earnings, but it will be applied to a lower self-employment income amount. The lower self-employment income will be equal to total self-employment income less the equivalent of an employer's social security tax payment on comparable wage or salary income. The full tax rate will be imposed on this lower income amount. Half of the resulting tax payment, equivalent to an employer's share, will be deductible. For individuals with income below the social security taxable maximum ($37,800 in 1984), the recomputation of income will have the same effect as a reduction in the tax rate of 1.17 percent—to 14.13 percent. The value of the additional tax reduction will vary depending on each individual's tax bracket.

### (C) SOCIAL SECURITY TAX BASE

Employer contributions made to pension plans under a variety of salary reduction arrangements under sections 401(k) and 403(b) of the Internal Revenue Code, which had previously been excluded from social security taxes, will be taxed and credited for social security, effective January 1, 1984.

### 3. BENEFITS

The Social Security Amendments of 1983 avoided substantial benefit changes in the short term, but accomplished most of the long-run savings through benefit changes affecting future beneficiaries. The short-term savings from benefit changes were split between a small proportional reduction in all benefits achieved by delaying the annual COLA, and a more substantial reduction in the value of social security benefits to higher income beneficiaries achieved through a change in the tax treatment of benefits. Additional changes, having no significant effect on the trust funds, included a revision of the tax treatment of other disability and retirement income, and minor improvements in social security benefits for divorced, disabled, and surviving spouses.

Congress made substantial long-run benefit changes to respond to anticipated increases in average worklife and to provide incentives for later retirement. The 1983 amendments scheduled a gradual increase in the social security normal retirement age—from age 65 to 67—beginning in the year 2000; accompanied by an increase in the delayed retirement credit and a moderation in the earnings test reduction.

#### (A) COST-OF-LIVING ADJUSTMENTS (COLA)

The 3.5 percent social security and SSI COLA, which had been due in July 1983, was paid in January 1984. Subsequently, the annual COLA will be paid each January based on the increase in the Consumer Price Index (CPI) between the third quarters (July to September) of the 2 preceding years. The delay in the COLA is designed to reduce real annual social security incomes by a fixed amount equal to half of the COLA, without lessening the benefit amount on which future COLA's will be calculated. To offset the effect of the COLA delay for SSI recipients, the Federal SSI payment standard was raised in July 1983 by $20 for a single individual (to $304.30) and $30 for a couple (to $456.40).

In 1983, the 6-month delay of the July 3.5 percent COLA resulted in an across-the-board 1.75 percent reduction in real social security income. For 1.9 million elderly and disabled social security beneficiaries who also receive SSI, the maximum $15 loss in monthly income from the COLA delay was more than offset by the $20 and $30 a month increase in benefits. However, nearly 2.4 million elderly poor social security beneficiaries do not receive SSI and were not protected from the effects of the COLA delay.[15] In addition, it is estimated that more than 250,000 persons age 62 and older with incomes just above the poverty level, were brought below the poverty level as a result of the social security COLA delay.[16]

---

[15] Social Security Administration. Annual Statistical Supplement, 1982. Table 9.

[16] Borzilleri, T.C. The Effect of Changes in Social Security Cost-of-Living Provisions on the Income Distribution of the Elderly. A study prepared for the American Association of Retired Persons. Mar. 10, 1983. p. 4.

### (B) TAXATION OF BENEFITS

Effective January 1, 1984, taxpayers receiving social security benefits became liable for taxes on half the amount by which the sum of their adjusted gross income plus half of their social security benefits exceeds $25,000 if single, or $32,000 if married and filing jointly. Those married and filing separately are all taxed on half of their benefits. In no case does more than half of the social security benefit become taxable. Income from tax-exempt municipal bonds is included in the calculation of adjusted gross income solely for the purpose of determining the proportion of the social security benefit that is taxable. Benefits from railroad retirement tier I and workers' compensation will be treated in the same manner.

This change in the tax treatment of benefits is expected to affect only 7 percent of all social security beneficiaries. One-fourth of those affected will be taxed on less than half of their benefits.[17] Because of the graduated application of the tax, the full tax will apply only to those whose adjusted gross income exceeds the $25,000/$32,000 limit by more than half of their social security benefit. For example, an elderly couple receiving $12,000 in social security benefits will be taxed on half of the benefit if their adjusted gross income equals or exceeds $38,000. The added tax resulting from this change is estimated to equal approximately 2 percent of the income of the elderly beneficiaries affected.

The percent of social security beneficiaries affected by the tax will increase substantially as rising incomes drive larger percentages of successive generations above the limits. Assuming that the limits are not adjusted in the future, revenues from this provision are expected to grow considerably (relative to social security taxable payroll). Taxing benefits will yield average annual revenues equal to 0.33 percent of payroll between 1983 to 2007, rising to 0.75 percent of payroll between 2033 and 2057. On average over the entire 75-year period, the provision to tax half of the social security benefit, if unchanged, is expected to yield nearly a third of the additional long-run financing provided by the 1983 amendments.

### (C) ELDERLY TAX CREDIT

The elderly tax credit and the disability income exclusion were revised to establish greater uniformity in the overall tax treatment of retirement and disability income. The elderly tax credit is a 15-percent credit on taxable, unearned income designed to extend the tax advantages of social security benefits to retirees with income from other sources. Prior to 1984, individuals 65 and over could claim a credit of 15 percent of a base amount up to $2,500 (single) or $3,750 (couple), reduced by the amount of any social security or railroad retirement benefits, or half the amount of any other income in excess of $7,500 (single) or $10,000 (couple). Individuals under 65 receiving income from a public retirement system could claim the credit without reduction. The disability income exclusion allowed permanently and totally disabled individuals under 65 to exclude up to $100 a week of benefits from an employer's disability plan. The amount excluded was reduced by any adjusted gross income in excess of $15,000 a year.

---

[17] U.S. Congress. Joint Committee on Taxation. Unpublished estimates, 1983.

As a result of the 1983 amendments, the base amount for the elderly tax credit was doubled, effective January 1, 1984. The elderly tax credit previously available to individuals under 65 receiving public pensions was replaced with a tax credit available instead only to persons receiving disability income. The disability income exclusion was eliminated.

### (D) SPOUSE BENEFITS

Four provisions improve benefits for surviving, divorced, and disabled spouses. Beginning in 1984, divorced or disabled survivors drawing benefits will be able to remarry without losing their benefits, and disabled widows will receive benefits at age 50 that are comparable to those payable otherwise at age 60. Beginning in 1985, divorced spouses will be able to collect benefits when they retire without having to wait for their former spouse to begin drawing benefits, and deferred survivors' benefits will be indexed after the death of the worker for wage increases, instead of price increases, until the survivor begins drawing benefits.

### (E) DELAYED RETIREMENT CREDIT

The delayed retirement credit is an adjustment to monthly benefits that compensates workers who defer receiving benefits after the normal retirement age of 65. The current credit of 3 percent per year provides less than a full actuarial increase in benefits, resulting in a benefit loss to workers who delay retirement. Beginning for workers reaching age 62 in 1987, the delayed retirement credit will increase by one-half of 1 percent every other year until it becomes an 8 percent annual credit for workers reaching age 62 after 2004. An 8 percent credit is thought to be equivalent to a full actuarial increase and should eliminate the penalty for delayed retirement.

### (F) EARNINGS TEST

Social security beneficiaries who work have their benefits reduced by $1 for every $2 of earnings above the earnings limit—which in 1984 is $6,960 for those 65 and over, $5,160 for those under 65. Beginning in 1990, beneficiaries aged 65 and older will have their benefits reduced more gradually for earnings over the limit, losing $1 for every $3 of earnings.

### (G) RETIREMENT AGE

Currently, retirees may receive full social security benefits at age 65—the normal retirement age—but can retire as early as age 62—the early retirement age—with reduced benefits. As a result of the 1983 amendments, the age at which full social security retirement benefits are paid will gradually increase from 65 to 67. The increase will occur in two stages. For those who reach age 62 beginning in the year 2000, the retirement age will rise by 2 months a year until it reaches age 66 for those turning 62 in 2005. For those reaching age 62 beginning in 2017, the retirement age will again rise by 2 months a year until it reaches 67 for those turning 62 in 2022. Thereafter the retirement age will remain at 67.

The early retirement age will remain 62—60 for widows—but the actuarial reduction factor for early retirement will increase due to the increase in the normal retirement age. For those retiring at age 62, the reduction factor, now 20 percent, will rise to 30 percent. Medicare benefits will continue to be available at age 65.

TABLE 11.—EFFECTS OF RETIREMENT-AGE PROVISION IN PUBLIC LAW 98–21

| Year of birth | Retirement age (years/months), worker/spouse | Age 62 benefits as percent of PIA,[1] worker |
|---|---|---|
| 1937 (same as prior law) | 65/0 | 80.0 |
| 1938 | 65/2 | 79.2 |
| 1939 | 65/4 | 78.3 |
| 1940 | 65/6 | 77.5 |
| 1941 | 65/8 | 76.7 |
| 1942 | 65/10 | 75.8 |
| 1943 | 66/0 | 75.0 |
| 1944 | 66/0 | 75.0 |
| 1945–54 | 66/0 | 75.0 |
| 1955 | 66/2 | 74.2 |
| 1956 | 66/4 | 73.3 |
| 1957 | 66/6 | 72.5 |
| 1958 | 66/8 | 71.7 |
| 1959 | 66/10 | 70.8 |
| 1960 | 67/0 | 70.0 |
| 1961 | 67/0 | 70.0 |
| 1962 and after | 67/0 | 70.0 |

[1] Reduced retirement benefits will continue to be available to workers (and spouses) beginning at age 62 but at a greater reduction. For workers and spouses, the prior-law reduction factors (5/9ths of 1 percent per month for workers and 25/36ths of 1 percent per month for spouses) are retained for the first 36 months of benefits before age 65 and a new factor (5/12ths of 1 percent) is applied for each additional month. For older survivors, reduced benefits continue to be available at age 60 with the monthly reduction adjusted for each age cohort so as to maintain a 28.5 percent reduction at age 60—the same maximum reduction as occurred under prior law.

Source: Svahn, John A. and Mary Ross. Social Security Amendments of 1983: Legislative History and Summary of Provisions. Social Security Bulletin, v. 46, July 1983. Table B.

## 4. LUMP-SUM TRANSFERS

In response to social security's immediate and substantial need for revenue to make benefit payments in 1983, the Congress authorized three sets of transfers from the general fund as reimbursements for outstanding amounts owed to the OASDI trust funds. These transfers were necessary because no proposals to cut benefits of future beneficiaries or modify COLA's could have generated the savings needed within 2 years of enactment of the bill, and immediate major payroll tax increases were not acceptable in the midst of a recession. Within months of the enactment of the 1983 amendments, $20.2 billion was transferred to OASDI in payment for gratuitous social security wage credits given to military personnel for service prior to their coverage under social security in 1957; Defense Department underpayments of social security taxes for military service since 1957; and uncashed social security checks for which the trust funds had been debited but never reimbursed.

## 5. SAFEGUARDS

The combination of coverage, payroll tax increases, benefit adjustments, and lump-sum transfers improved the financing of OASDI by an estimated $166 billion between 1983 and 1989, and 2.10 percent of taxable payroll over the next 75 years, under intermediate assumptions. If the economy performs according to the midrange assumptions adopted by the board of trustees of the OASDI trust funds, this improvement will be sufficient to enable social security to continue paying retirement, survivors, and disability benefits for the foreseeable future. However, in the recent past, the midrange assumptions have proven to be overly optimistic. Should economic conditions prove worse than anticipated, funds for social security would become inadequate within a few years. To guard against this possibility, the Congress enacted four "fail-safe" provisions to protect the trust funds automatically if economic conditions deteriorate.

The most significant of the "fail-safe" provisions is an automatic COLA "stabilizer" designed to buffer the system's finances against unanticipated fluctuations in wages and prices. Between 1984 and 1988, whenever trust fund reserves fall below a trigger level of 15 percent of estimated outlays, the next annual COLA will be based on the lesser of the increase in a wage index or the Consumer Price Index. After 1988, the trigger level will be raised to 20 percent. If COLA's are reduced as a result of the "stabilizer," the reductions will be repaid to affected beneficiaries when trust fund reserves rise above 32 percent of estimated outgo.

Three additional "fail-safe" provisions went into effect immediately to insure that adequate reserves would exist for the payment of benefits through 1983 and thereafter. The first provision extended the authority of the three social security trust funds (OASI, DI, and HI) to borrow among themselves through 1987, subject to repayment. A second provision immediately changed the accounting procedures to credit anticipated monthly revenues to the OASDI trust funds at the beginning of each month. A third provision requires the board of trustees of the OASDI trust funds to notify the Congress when trust fund reserves decline to low levels and provide specific recommendations for statutory changes to restore adequate reserves.

Congress also reallocated the tax rates between the OASI and the DI trust funds so that both funds would have roughly comparable trust fund reserve ratios in the future.

## 6. OTHER PROVISIONS

A number of relatively minor provisions affecting social security financing, benefits, and taxes were enacted as part of the 1983 Social Security Amendments. Some of the provisions embodied recommendations from the National Commission on Social Security Reform intended to restore public confidence in the program.

### (A) SEPARATION OF TRUST FUNDS FROM THE BUDGET

The operations of the OASI, DI, and HI trust funds were removed from the unified budget, effective with the fiscal year 1993 budget. In the interim, OASI, DI, HI, and SMI trust fund accounts are to be shown as a separate function in the budget, effective with the fiscal year 1985 budget. This provision is intended to insulate the operation of these trust fund programs from the pressures of unrelated budget concerns.

#### (B) PUBLIC TRUSTEES

Two public members were added to the social security boards of trustees. Currently the Secretaries of Treasury, Health and Human Services, and Labor oversee the operations of the four social security trust funds. Under this provision, two public members will be appointed from different political parties by the President, with confirmation by the Senate.

#### (C) INDEPENDENT AGENCY STUDY

A study was authorized to determine how best to establish the Social Security Administration as an independent agency.

#### (D) ADDITIONAL STUDIES

In addition, the 1983 amendments called for a number of studies on policy questions raised during consideration of the financing issues. Among the studies specified in the amendments are two to be completed by the Secretary of Health and Human Services. The first is a study on the effects of increasing the social security retirement age on those who are unable to extend their working careers for health or occupational reasons, due January 1, 1986. The second is a report on the implementation of an earnings sharing plan, due July 1, 1984, with a review of the plan by the Congressional Budget Office due 30 days later.

## D. ISSUES RAISED BY THE AMENDMENTS

In the months after the enactment of the social security amendments, several social security issues were raised, mostly in response to provisions of the 1983 legislation. Only one of these issues—the social security coverage of senior Federal judges—was resolved in 1983. The rest of these issues remain before the Congress, with a 1984 resolution likely only of the social security coverage of churches.

### 1. Municipal Bond Interest

During consideration of the 1983 Social Security Amendments, the Senate Finance Committee adopted an amendment to include tax-exempt interest from municipal bonds in determining whether an individual's social security benefits are taxable. This amendment was added because it was realized that adjusted gross income (AGI), by itself, would be an inadequate measure of an individual's ability to pay. Without the inclusion of tax-exempt interest, an individual with a $30,000 taxable pension would be fully taxable on half of his benefits, while an individual with a $10,000 pension and $100,000 of tax-exempt interest would completely escape taxation on his social security benefits. The provision did not in any way affect the tax treatment of tax-exempt interest.

On April 20, 1983, Senator D'Amato introduced S. 1113 to repeal this provision in the social security amendments, and exclude tax-exempt interest from the determination of tax liability on social security benefits. Supporters of S. 1113 argued that the social security amendments would discourage the elderly from investing in tax-exempt municipal bonds, because, by including the interest in the determination of social security tax liability, it effectively levied a tax on the interest itself. Supporters of the repeal effort also claimed that the diminished demand for these bonds would substantially raise borrowing costs for municipalities.

Opponents of the repeal effort pointed out that had tax-exempt interest not been included, the elderly would have had a tremendous incentive to shift their assets into tax-exempt bonds to reduce their social security tax liability—resulting in a windfall for the municipal bond market. Further, opponents argued, the inclusion of tax-exempt interest did not eliminate the tax advantage in tax-exempt bonds—because the interest itself remains nontaxable, and the marginal tax rate applied to the social security benefits of those with tax-exempt interest will be lower than the rate applied to those without tax-exempt interest. Opponents discounted claims that the social security amendments would hurt the municipal bond market—although clearly the repeal of the tax-exempt provision would help them.

The Senate Finance Committee held hearings on S. 1113 on August 1, but it is unlikely that further action will be taken on this matter.

### 2. SENIOR FEDERAL JUDGES

The Social Security Amendments of 1983 extended social security coverage to all sitting Federal judges, effective January 1, 1984. The definition of sitting judges specifically included retired judges who have elected to remain in senior status and receive cases. Section 101c of the act defined the pay of senior status judges as "wages" for the purpose of applying both the social security tax and the earnings limit.

Federal judges reaching the age of 65 with 15 years service (70 with 10 years) have the option of remaining in "regular active service," retiring in senior status, or retiring fully. A retired judge in senior status can request to receive a prescribed number of cases and thereby remain active. Retired judges receive retirement pay equivalent to their pay as a Federal judge ($73,700). Currently there is no difference in compensation between active, senior status, and retired judges—under prior law, neither active nor retired judges were taxed for social security.

The Congress included senior status judges in the social security coverage of Federal judges to treat both types of working judges equally and eliminate any economic advantage in electing senior status. However, the equity achieved between active and senior status judges resulted in an inequity between senior status and retired judges, and a significant financial incentive for senior status judges to retire completely. First, active and senior status Federal judges would begin in 1984 paying $2,646 a year in social security taxes. Second, senior status judges who were receiving or would have been entitled to social security benefits would lose them as a result of the earnings limit. Third, there was concern that retirement pay to senior status judges could also become subject to State and local income taxes as well. The combination of these tax effects could have resulted in a $10,000 or more reduction in net income for a retired judge in senior status, and a strong financial incentive to retire completely.

The Administrative Office of the U.S. Courts and a number of Federal judges expressed concern that implementation of the social security coverage provisions would cause most senior status judges to retire. Loss of a substantial number of senior judges would further burden the Federal court system, since senior judges now dispose of about 10 percent of the system's caseload.

Two bills were introduced in the Senate to repeal the social security coverage of senior status judges: S. 1276 by Senator Mitchell and S. 1375 by Senator Specter. However, there was little support for a full repeal since this would create an inequity between active and senior status judges.

The Congress did pass a provision as part of the Federal Supplemental Compensation Act (H.R. 3929) to delay the coverage of senior judges until January 1986. The purpose of the delay was to prevent wholesale retirement in 1984 and give the Administrative Office of the U.S. Courts time to develop changes in the compensation of senior status Federal judges to offset the anomalous effects of social security coverage.

### 3. Social Security Coverage of Churches

Beginning January 1, 1984, as a result of the 1983 Social Security Amendments, most religious organizations were required to join the social security system. Previously, religious and other nonprofit organizations could elect to participate voluntarily in social security. The mandatory coverage of churches has aroused controversy because some religious groups oppose being forced to join the system.

In response to numerous complaints from religious organizations and clergymen about the 1983 changes in the law, Senator Jepsen introduced legislation (S. 2099) to delay mandatory coverage of religious organizations until January 1, 1986. The Senate Finance Committee held a hearing on the bill on December 14.

Some religious groups have complained that mandatory social security coverage of churches violates the constitutional principle of separation of church and state. They allege that the employer's share of the tax is a tax on the church itself. If left unchallenged, it could lead to further encroachment by the Government into functions of religious organizations. Beyond this, some religious orders contend that compliance with the social security law requires members to violate tenets of their faith. Some have argued that churches, particularly those made up of low-income persons, might have difficulty absorbing the increased operating costs. Churches rely largely on the ability and willingness of the congregation to make higher contributions.

Proponents of the mandatory coverage provision argue that social security should be universal for all workers and that exceptions undermine the concept of social insurance. Optional coverage of nonprofit institutions as it existed prior to the 1983 amendments allowed some workers to reap high benefits relative to their social security tax payments because they may have worked only the minimum amount of time needed to gain benefit eligibility. Religious and other nonprofit groups often pay low salaries and many of their low-income workers, those who might have the greatest need for eventual social security protection, would be hurt by the lack of it.

Proponents also argue that mandatory coverage of these groups does not violate, as some critics have said, the first amendment of the Constitution, which precludes the Government from interfering with the affairs of the church. The new law does not involve the Government in religious functions, they contend, but merely enables society to protect workers of religious entities. The new provision largely affects lay employees. The law still permits exemptions from taxation and coverage for clergymen and certain members of groups opposed to social insurance.

Since the churches appear primarily concerned with the imposition of the tax on the church as an employer, it is possible that a compromise may be worked out in 1984 that would enable employees of churches opposed to paying the tax to be covered as self-employed.

### 4. The Social Security "Notch"

In 1983, interest was revived in the social security "notch" problem, largely as the result of a series of misleading newspaper columns on the subject by a nationally syndicated columnist (it was not related to the 1983 amendments). The "notch" is a difference in monthly social security benefits between those born in 1916, and those born in 1917 or later, resulting from a change in the social security benefit formula enacted in the 1977 amendments. The difference is substantial only for those in the highest benefit levels who defer retirement until age 65. It became most noticeable as individuals born in 1917 reached age 65 in 1982.

The problem stems from a series of changes the Congress made in the social security benefit formula, beginning over a decade ago. In 1972, the Congress enacted automatic annual indexing of both the formula to compute initial benefits at retirement, and of benefit amounts after retirement. The intent was to eliminate the need for ad hoc benefit increases, and to fix benefit levels in relation to economy. However, the method of indexing the formula had a flaw in it—known as "double indexing"—which caused initial benefit levels to rise rapidly in relation to the preretirement income of beneficiaries. Before the 1972 amendments took effect, social security replaced 38 percent of preretirement income for an average worker retiring at age 65. The error in the 1972 amendments caused replacement rates for the average worker retiring at age 65 to rise as high as 55 percent for the cohort born in 1916.

Without a change in the law, the average worker retiring around the turn of the century would have been receiving more in monthly social security benefits than he was earning prior to retirement. This projected growth in relative benefits was the cause of the long-run deficit in 1977 estimated at 8.2 percent of taxable payroll. Had the Congress elected to finance this increase rather than reduce benefits, it would have had to double the social security tax rate. Instead, in the 1977 amendments the Congress chose to recoup part of the increase in relative benefits and finance the remaining benefit increase with a series of scheduled tax increases. Future benefits for the average worker under the new formula were set at 42 percent of preretirement income.

The intent of the 1977 legislation was to create a relatively smooth transition between those retiring under the old method and those retiring under the new method. Unfortunately high rates of inflation in the late seventies and early eighties made the differences between the cohorts born before and after 1917 greater than intended. The difference became most extreme for those who deferred retirements, particularly those with maximum earnings. For two maximum earners with identical earnings histories, one born in 1916 and the other in 1917, the difference in benefits for retirement at age 62 was only $7 a month. However, these same individuals retiring at age 65 received benefits differing by $111 a month.

Although the "notch" is actually the result of an uncontrolled increase in benefits for those retiring under the old formula, and does not reflect any reduction in real benefits to those retiring under the transition rules, it was perceived as a benefit reduction by those affected. Congress responded to the complaints of this group by introducing a series of proposals for relief, most of which would give benefit increases to "notch-year" retirees at a high cost to social security. For example, one bill introduced by Representative Frank (H.R. 1965) would guarantee 1916-cohort benefit levels until nominal benefit levels under the new formula surpass them. The bill would produce an immediate 12-percent increase for beneficiaries who retire at age 65, at an estimated cost to social security of from $15 to $20 billion between 1983 and 1990.

## E. ADMINISTRATION OF SSA

With legislation enacted by April restoring the financial solvency of the OASDI trust funds, the Congress began to turn its attention toward the end of 1983 to the problems of administering the social security program. The Special Committee on Aging, in hearings on November 29, raised the question of how well the Social Security Administration (SSA) is serving the public. Officials from SSA, the General Accounting Office (GAO), and line workers from the Social Security field offices, testifying at the hearing, reviewed factors which have contributed to the deterioration in the quality of SSA's public service in recent years.

In November, the Congressional Panel on Social Security Organization, established under section 338 of the Social Security Amendments of 1983, convened its first meeting to initiate a study of how to establish SSA as an independent agency.

### 1. Background

The Social Security Administration (SSA) is the agency in the Department of Health and Human Services with administrative responsibility for the Department's income security programs. SSA administers the trust funded cash payment programs: Old-age and survivors insurance (OASI), disability insurance (DI); and the general revenue financed income transfer programs; supplemental security income (SSI), and grants to States for aid to families with dependent children (AFDC).

SSA is the fourth largest agency in the Federal Government, with a $195 billion budget in fiscal year 1984—$190 billion for cash payments to beneficiaries, and $5 billion for administration. In the trust fund programs (OASI and DI), SSA spends less than 1.5 percent ($2.6 billion) of the total cost of the program on administration.

The functions of SSA enter into the lives of nearly every American. SSA has issued over 270 million social security numbers, over 235 million persons qualify for retirement and survivors protection. Each year 115 million workers are engaged in covered employment, and each month SSA makes payments to more than 38 million beneficiaries. In addition to operating the OASI, DI, and SSI programs and managing grants to States for AFDC, SSA carries out most of the day-to-day operations of the medicare program, administers black lung—part B payments, takes food stamp applications, and administers the low-income energy assistance, refugee assistance, and child support enforcment programs.

SSA employs (as of September 1983) a total of 87,353 personnel nationwide to provide services to beneficiaries. Of these, 74,511 are full-time permanent employees. At SSA headquarters in Baltimore, 9,900 employees provide policy and program direction to the field offices. Another 5,000 employees operate SSA's computer system. SSA has 10 regional commissioners with line authority over the 1,340 district and branch offices, 3,400 contact stations, and 33 teleservice centers which serve as the primary point of contact for the public. Over 42,000 employees work in SSA's field offices. Six program service centers (PSC's) review and approve transactions the field offices cannot handle. Over 15,500 employees are employed in the PSC's and in the Office of Disability Operations in Baltimore. The Office of Hearings and Appeals, with 4,700 employees in hearings offices, process claimant requests for hearings before an administrative law judge (ALJ) to review a reconsideration or determination of benefits.

## 2. Aging Committee Hearing

On November 29, the Special Committee on Aging held a hearing entitled "Social Security: How Well Is It Serving the Public?" While the operating mission of SSA is to "pay the right check to the right person at the right time," there is evidence that SSA has been having increasing difficulty fulfilling this mission.

While the OASI program is the simplest program SSA has to administer, a surprising number of OASI beneficiaries receive erroneous social security payments during their retirement due to administrative error. A study completed by GAO and SSA in time for the hearing indicated that nearly 19 percent of all retired beneficiaries (one beneficiary in five) receive a check with the wrong amount due to an SSA error some time within their first 5 years on the program. In 60 percent of the payment error cases, the errors had not been corrected at the time of the study. While many of the payment errors were relatively small, in a third of the cases the error was in excess of $500, and on average the payment errors affected 4 to 5 months of checks. Furthermore, SSA's mistakes were three times as likely to result in an underpayment to the individual as an overpayment.

Because the GAO/SSA study focused on the experience of beneficiaries over time, it produced a substantially different view than SSA and the Congress have previously had of payment accuracy in the OASI program. SSA contends, based on a review of 1-month's payments, that OASI payment error rates are low, and that most payment error is caused by the failure of beneficiaries to properly report postentitlement events. In the most recent sample of cases (October 1981), SSA found that SSA-caused payment error occurred in 9 percent of the OASI cases that month (0.6 percent overpayment, 8.4 percent underpayment). Fewer than 1 percent of program dollars were paid in error in that month.

In addition to payment error, witnesses identified problems with processing delays and overpayment recovery methods. Social security beneficiaries testifying at the hearing noted the unreasonable amount of time required to correct a payment error: 14 months to change a date of death in one case, nearly a year to repay an erroneously recovered check, and 9 months to pay an improperly withheld check.

Delays occur almost routinely when manual processing is required. Most manual processing takes place at the six program service centers (PSC's) and requires reference to paper folders. This processing normally takes from 4 to 6 weeks, but in the last 2 years, backlogs in manual processing at the PSC's have become severe. Despite recent computer improvements, actions pending at the PSC's increased by 50 percent in the last year to nearly 2 million.[18] Delays in postentitlement processing may not only deprive beneficiaries of income but also cause overpayments necessitating recovery action.

A recent SSA initiative to accelerate the recovery of overpayments has also created problems. Beneficiaries testifying at the hearing cited instances in which SSA had made aggressive efforts to recollect overpayments which had already been recovered. Testimony also brought to light a policy of the Treasury Department and SSA to recover direct deposit payments from the bank accounts of deceased individuals without prior notification. In two cases reviewed at the hearing, Treasury had mistakenly recovered payments from individual's bank accounts as a result of SSA processing errors. Witnesses also testified on the effect of the emphasis on debt collections on workloads for field office personnel. The added burden of this initiative came at a time of staff shortages and a governmentwide hiring freeze.

GAO testimony reviewed the changes which have occurred outside the control of SSA which have complicated the operations of the agency. In recent years, significant political, organizational, and legislative changes have occurred which have added substantially to the complexity of SSA's programs and the internal disorganization of the agency. Until the early 1970's, SSA was a reasonably stable and simple organization. However, in just the last 10 years:

---

[18] Social Security Administration. Interview with Deputy Commissioner Doggette. OASIS, v. 29, September 1983.

—Congress has enacted 16 major laws affecting OASI and DI benefits, five making significant changes in entitlement and benefits.

—SSA has taken over responsibility for several nontrust fund programs, including SSI and AFDC.

—Eight different commissioners have been appointed to run SSA—compared to only five in the previous 35 years.

—SSA has been reorganized four times—three of them in 5 years; and

—Court activity has increased substantially—with a large number of cases involving due process rights in social security appealed to the Supreme Court in the last decade.

These and other changes have made the district offices more pressured and chaotic places to work. SSA claims representatives testified at the hearing that increasing workloads and staff cutbacks at the district offices and backlogs at the program service centers have eroded productivity and performance of the district offices. Public service, once the major function of the district office, has increasingly been sacrificed in the crush of claims processing and postentitlement paperwork.

SSA testimony emphasized the role of computer failure in the processing difficulties and reviewed the progress now underway in improving the computer system. SSA Commissioner McSteen testified that deterioration in the computer system had accompanied the growth and increasing complexity of SSA's workload. The four basic reasons for systems problems have been: Outdated and patchwork software; unreliable and outdated computer equipment; use of magnetic tape (half a million reels) for file storage; and an inadequate telecommunications system for the transmission of data from the field offices. Currently, SSA is in the second year of a 5-year systems modernization plan, aimed at correcting many of these problems. SSA intends to implement a field office enhancement project within the next few years to enable field office staff to get information quickly and replace most of the manual computation now required in SSA's processing. The Commissioner stated her view that this improvement in the computer system would eliminate most problems of error and delay now occurring in the program.

### 2. INDEPENDENT AGENCY STUDY

It has often been suggested, as a solution to SSA's management and operational problems, that SSA be separated from the Department of Health and Human Services and sheltered from interference of governmentwide management agencies. Supporters view this step as a way to stabilize the agency and restore public confidence in the management and integrity of the social security program. Independent agency status, it is argued, would reduce the duplication of functions, fluctuation of policy and priorities, turnover of management, and overutilization of limited agency resources.

The National Commission on Social Security Reform included, in a series of proposals for restoring public confidence in social security, a statement by the majority of members that "* * * it would be logical to have the Social Security Administration be a separate independent agency, perhaps headed by a bipartisan board * * *" and a recommendation that a study be conducted on the feasibility of an independent agency. Based on this recommendation, the Congress mandated, in the Social Security Amendments of 1983, the creation of a study panel to review and report findings on implementation issues surrounding SSA's removal from the Department of Health and Human Services and its establishment as an independent agency.

The resulting three-member Congressional Panel on Social Security Organization was appointed in October by the chairman of the House Ways and Means and Senate Finance Committees. The congressional panel, chaired by Elmer B. Staats, former Comptroller-General, met for the first time on November 23.

The panel has set as its goal the review of three groups of issues: The type of top-level organizational structure to recommend; the relationship of the independent agency to related agencies and programs and to governmentwide management agencies; and the programs to recommend including in the independent agency. Under Public Law 98-21, the panel is directed to report its findings and recommendations to the Congress no later than April 1, 1984.

## F. PROGNOSIS

With the enactment of the 1983 Social Security Amendments, for the first time in a decade, the Congress faces no short- or long-run solvency crisis in the social security cash benefit programs. As long as the OASDI trust funds remain solvent, there will be little interest in the Congress in raising further financing questions. It is remotely possible that sometime within the next 2 years, while the OASDI trust funds remain at minimal levels, the "COLA stabilizer" could be automatically triggered, causing the COLA paid in January 1985 or 1986 to be somewhat lower than the full percentage increase in the CPI. But this possibility is not presently, by itself, a source of great concern in the Congress.

Congressional and public concern about financial solvency is now focusing instead upon the threatened depletion of the medicare (HI) trust fund. This trust fund is expected to be exhausted, by current estimates, in 1990. Restoration of the HI trust fund will most likely force the Congress to consider broad reform of the entire method of financing health care in the United States before the end of this decade.

In the social security cash benefits programs, attention will remain focused on the pressing need for reform in the disability insurance program (see chapter 7 on disability insurance) and on the need within SSA to restore the quality of its service to the public. These two issues are of immediate interest to the Congress.

An equally important, but less urgent, issue in social security is the need to restructure social security to improve the equity and adequacy of benefits for women.[19] Although the National Commission on Social Security Reform did not recommend substantial reforms to improve benefits for women, it did include a statement in the final report that "some members of the National Commission believe that there should be a comprehensive change in the program to reflect the changing role of women, for example, by instituting some form of earnings sharing for purposes of the social security earnings record." [20] In addition, the Social Security Amendments of 1983 directed the Secretary of HHS to report recommendations for earnings sharing proposals to the Congress by July 1, 1984. It is likely that sometime within the next few years, the Congress will begin to consider changes in the social security program to improve its responsiveness to the needs of women.

---

[19] For a more complete treatment of women's benefits issues see: U.S. Congress. Senate Special Committee on Aging. Developments in Aging: 1982, v. I. Washington, U.S. Govt. Print. Off., 1983. pp. 120-122.

[20] Report of the National Commission on Social Security Reform, January 1983. Washington, U.S. Govt. Print. Off., 1983. pp. 2-28.

# Chapter 4

# EMPLOYEE PENSIONS

## OVERVIEW

In contrast to 1982, which saw relatively little legislative activity concerning employee pensions, Congress showed renewed interest in pension benefit issues during 1983. The first half of the 98th Congress produced several significant enactments, and a number of important legislative proposals were still pending as Congress recessed at the end of the year.

Included in the Social Security Amendments of 1983 (Public Law 98-21) was a provision which, for the first time, brings new Federal employees under social security. This provision not only gave Congress an opportunity to consider retirement benefits for new employees, but to reconsider such benefits for former and present employees as well. The result was a commitment to a study of the present civil service retirement system with a 1985 target for additional reform. The past year also saw the enactment of the Railroad Retirement Solvency Act (Public Law 98-96), legislation needed to insure the solvency of the railroad retirement system and to redistribute the burden of financing benefits.

Several additional legislative initiatives were introduced during 1983, but were carried over to the second session of the 98th Congress for final disposition. Pending legislation would change present pension law to provide pension equity for women, and reform the single employer termination insurance program to avert possible insolvency of the Pension Benefit Guaranty Corporation. Other issues which received attention include asset reversions following plan terminations, pension fund investment practices, enforcement of fiduciary provisions, Federal regulation of State and local pension plans, and Federal expenditures for military retirement.

## A. PRIVATE PENSION PLANS

### 1. Historical Development

While the earliest pension plans were offered toward the end of the 19th century, private and public pension plans have only become a significant factor in the provision of retirement income in the last 30 years. The early development of private pensions was spurred primarily by the desire of employers to improve labor stability and productivity. Pensions were variously viewed as a way of encouraging loyalty and long service, as a means of reducing worker turnover, and, coupled with mandatory retirement, as a way of humanely removing superannuated employees. Federal tax laws added a further incentive to employers by allowing them to exempt contributions to pension plans from corporate income taxes. Employers establishing pension plans were frequently supported by unions, who saw the pension plans as a moral obligation of the employer to compensate workers for depreciation over a career of employment.

Civil service pensions were also initiated in the 19th century, beginning with the development of State and local government plans for firemen, policemen, and teachers. It was not, however, until the 1920's that public pensions began to increase in prevalence and coverage. Mounting concern about government efficiency and the problem of superannuated Federal employees led to the establishment of the Federal civil service retirement system in 1920. Pension plans for State and local government employees also became more popular in the 1920's. But major expansion in public employee pensions did not come about until the 1940's and 1950's. At the Federal level this trend was a result of the burgeoning Federal work force during and after World War II. At the State and local level, professionalization of government employees, a desire to avoid social security coverage of government employees, and an increasing awareness of retirement income needs contributed to the growth of public employee pension coverage.

The development of private pension plans, which had been slow in the 1920's and 1930's, also began to increase rapidly in the 1940's and 1950's. This sudden increase was the result of three factors. First, tax sheltering of corporate and personal income became more important when personal and corporate tax rates were raised precipitously in 1940. Congress, responding to these heightened tax incentives, tightened the requirements for qualification of a plan and improved the tax advantages for qualified plans in the Revenue Act of 1942. Under the terms of this act, qualified plans could realize three tax advantages: (1) Tax deductibility of employer contributions; (2) tax deferral of plan investment income; and (3) tax deferral of employer contributions until pension benefits were received in retirement. These added advantages provided tremendous incentives for the expansion of qualified pension plans.

A second factor was that firms were forced, as a result of wage freezes during World War II and the Korean war, to provide compensation increases to workers in the form of benefits instead of cash wages.

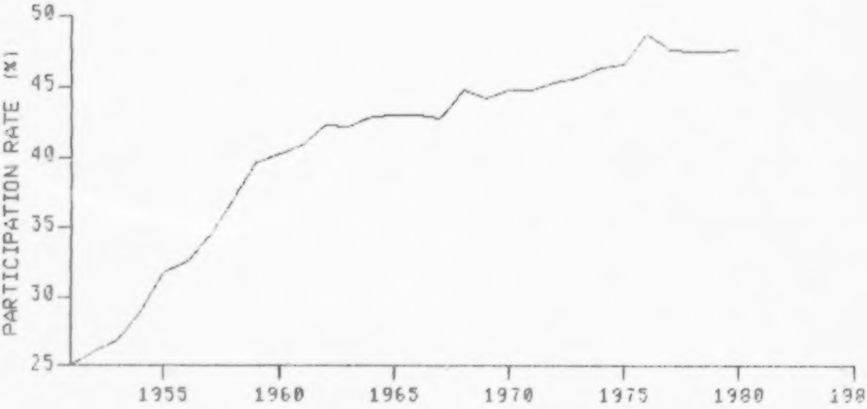
A third factor was that labor unions became increasingly interested in the 1940's in including pension benefits in negotiations for compensation. Union interest in pension benefits stemmed from the settlement of the mineworkers strike in 1946 which included the establishment of the mineworkers pension fund. Union interest was further spurred by the 1949 Supreme Court decision in the *Inland Steel* case, which upheld the National Labor Relations Board's decision that pension and welfare benefits were a proper subject for collective bargaining. Increasing recognition by unions that social security benefits were inadequate, coupled with the finding by the Steel Industry Factfinding Committee in 1949 that the steel industry had a social obligation to provide pensions to workers, further fueled the pursuit of pension benefits through labor negotiation. By 1950, nearly all major unions had successfully negotiated pension plans.

The change in incentives for the formation of private pension plans after 1940 produced a rapid expansion in both the number of pension plans and the proportion of the private wage and salary labor force covered by pensions. In the first 20 years after 1940, the growth in pension coverage was particularly rapid due to the immediate development of pension plans by the largest employers. As the number of qualified pension profit-sharing and stock bonus plans increased from 700 to 64,000,[1] the proportion of workers covered by private pensions increased from 12 percent to about 33 percent.[2]

In the second 20-year period, the expansion of coverage slowed considerably due to a trend toward coverage of workers in smaller firms. While pension coverage had increased at an average annual rate of 12 percent in the 1940's and 7 percent in the 1950's, between 1960 and 1974, pension coverage grew at a rate of only 3 percent a year. Overall, the proportion of covered workers increased from 33 percent to only 40 percent.[3]

CHART 1

WAGE AND SALARY WORKERS (NON-AGRICULTURAL), PERCENT PARTICIPATION IN PRIVATE PENSION PLANS 1,950-1980



SOURCE: Schieber, Sylvester. Social Security: Perspectives on Preserving the System. Employee Benefit Research Institute, 1982. From IRS data. Table II-1.

During this same period, however, the number of qualified plans in effect increased dramatically from 64,000 to nearly 425,000. By the early 1970's, although there was an average net increase of 50,000 new plans a year, the rate of worker participation in plans was leveling off.[4]

---

[1] Spencer, Charles, and Associates. Pension and Profit-Sharing Plans in Effect, Based on IRS Data. EBPR research reports, 1939-75.

[2] Schultz, James H. The Economics of Aging. 2d edition Belmont, Wadsworth, 1980, table 23.

[3] Ibid., p. 126, and table 23.

[4] Spencer, Charles. Pension and Profit-Sharing Plan.

## 2. CHARACTERISTICS OF PRIVATE PENSION PLANS

### (A) TYPES OF PENSION PLANS

Today there are more than 52 million private sector wage and salary workers actively participating in one or more of over 496,000 private pension plans.[5] These pension plans are of two types—defined benefit, and defined contribution plans. Defined benefit plans, which account for about 30 percent of all plans and 70 percent of all participants, are plans which pay the workers a specified benefit frequently based on a combination of his years of service, and recent earnings experience. Defined contribution plans, which account for about 70 percent of all plans and only 30 percent of all participants, are plans in which the rate of contribution is specified, and benefits are unpredictable—since they are tied to the rate of return on the plan's investment.[6]

The majority of pension plans are small. As of 1978, 65 percent of all plans had fewer than 10 participants, and 93 percent of all plans had fewer than 100 participants. Three-fourths of those plans with fewer than 100 participants are defined contribution plans. Defined benefit plans tend to be larger: two-thirds of all plans with over 100 plan participants are this type. Defined benefit plans had an average size of approximately 260 participants, while defined contribution plans had 45 participants per plan.[7]

Small employers tend to sponsor only one pension plan, typically a profit-sharing or money-purchase plan. Most large employers also only sponsor one plan, but it is most likely to be a defined benefit plan. A significant number of large corporate employers, however, provide both a basic defined benefit plan and one or more defined contribution plans.[8]

Defined benefit plans pay either a flat-rate benefit or an earnings-related benefit. Flat-rate plans, also called "pattern plans," cover primarily employees paid hourly wages in collectively bargained plans. These plans pay a fixed dollar amount to the participant each month per each year of service under the plan.

Earnings-related plans, also called "conventional plans," generally cover salaried employees or a combination of salary and wage employees, and pay benefits in proportion to the worker's earnings. Usually the benefit is derived by multiplying a percentage of the employee's average earnings over some specified period by his years of service under the plan. The earnings which are averaged in calculating the benefit may be the worker's career earnings under the plan, but they are often the worker's highest 3 or 5 years of earnings, or the worker's earning in his final 5 or 10 years of employment. The aim of an earnings-related plan is to pay the worker some fixed proportion of preretirement earnings to assure that pension benefits bear a set relationship to employees' standards of living, regardless of what happens in the economy. In general, final earnings and high years' earnings formulas pay initial benefits which have a more direct relationship to the employees' final preretirement standard of living than do the benefits paid under career average formulas.

---

[5] U.S. Dept. of Labor. Estimates of Participant and Financial Characteristics of Private Pension Plans, 1983, p. 1.

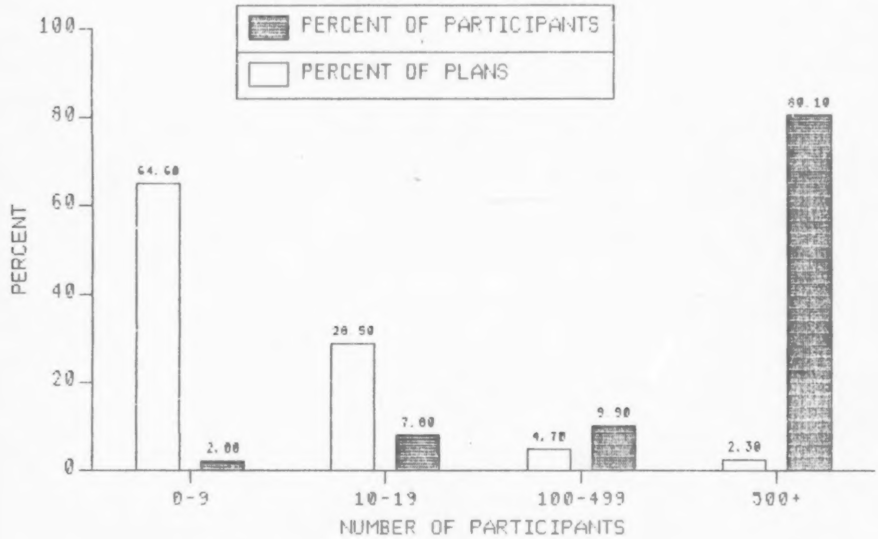
[6] Ibid.

[7] Ibid.

[8] Ibid.

CHART 2

PERCENT OF PENSION PLANS AND PLAN PARTICIPANTS
BY PLAN SIZE
1978



Source: U.S. Dept. of Labor, Estimates of Participant and Financial Characteristics or Private Pension Plans, 1978; Tables 1a and 2A.

These features make the defined benefit plan advantageous to a worker who remains with a single employer throughout his career. However, several features of these plans tend to penalize mobile workers. Most participants in defined benefit plans have to work for the same employer for 10 years to become vested for pension benefits. A worker who leaves early not only loses his right to benefits, but also is unlikely to have made any contributions to the plan which he could otherwise withdraw. A worker who stays with the same employer for more than 10 years, but leaves that employer several years before retiring, will find upon retirement, that the purchasing power of this fixed dollar pension has been eroded by inflation. These features of defined benefit plans tend to penalize mobile workers.

Employers can offer defined benefit plans as a way of rewarding loyal employees and reducing their labor turnover. In addition, the benefit formula can be set to influence employees decisions about work and retirement. However, there are several disadvantages for the employer as well. Employers who offer defined benefit plans are obligated to provide the benefits they have promised. If their assumptions about future plan performance prove to be optimistic, employers may find it necessary to increase their contributions to finance the benefits. In this sense, the employers' pension costs are uncertain and deterioration in the economy can lead to the build up of large unfunded pension liabilities.

Defined contribution plans include money-purchase and profit-sharing plans. In money-purchase plans, a periodic contribution of a specified percentage of earnings is set aside in an individual employee account. In profit-sharing plans, the periodic contributions to each account are a function of the profits of the firm and may vary each year. In both cases benefits are paid out based on the funds which have accumulated in the individual account at the time of retirement.

Defined contribution plans cannot offer the worker predictable benefits, since the benefits paid depend upon the performance of investments. Individual employees may find upon retirement that the benefits paid are less than or greater than the benefits projected by the plan. In this sense, the employee, and not the employer, bears the risk. Defined contribution plans, however, have the advantage of not extracting as heavy a penalty for job mobility. Defined contribution plans are likely to allow the employee to gradually vest in his pension benefits, and are also likely to include employee contributions. Thus, even workers who leave before fully vesting can take some benefits with them. In addition, since the employee has an account which is vested, there is continuing growth in the value of his benefits even after he leaves the employer. As a result, benefits paid by defined contribution plans tend to be less sensitive than benefits paid by defined benefit plans to employee's job changes.

By the same token defined contributions are difficult for an employer to use in rewarding career workers or influencing the work and retirement choices of employees. There is an advantage to offering a defined contribution plan, however. The employer's liability is limited to the periodic contributions it makes to the plan. Once these contributions are made, the employer has no further financial obligation.

It is important to realize that, in practice, the choice of a defined benefit or a defined contribution plan is not mutually exclusive. Major employers who include defined benefit plans in their benefit package often supplement those benefits with defined contribution plans which may be specifically targeted to attract highly skilled workers with relatively short tenures. They are also a way of increasing benefits without increasing the employer's future liability.

A second way to look at pension plans is to differentiate between plans sponsored by a single employer and those sponsored by a group of employers or employers and labor organizations. Single employer plans are the most common, covering about 85 percent of all participating workers. In these plans, the employer sponsors and either administers or contracts for the administration of the plan separately.

Multiemployer plans usually cover employees in an industry or craft in a specified geographic area. These plans require employers to make specified contributions on behalf of each worker to a central fund. Employees can continue to accumulate years of service under the plan by working for any of the employers in the plan. While the contribution rate is determined through collective bargaining, benefits are defined by the plan's trustees who are representatives of labor and management. Multiemployer plans offer workers better portability of their pensions than single employer plans because years of service continue to be credited to the workers account as he moves from one participating employer to another. However, benefit guarantees in multiemployer plans may not be as sound. While benefits are fully protected if a particular employer leaves the plan, if the plan terminates, workers benefits are only partially protected by plan termination insurance. Multiemployer plans can also be a problem for the employer. The defined benefits promised by the plan leave employers liable for future benefit obligations, as in single employer defined benefit plans, but in multiemployer plans employers share control over benefit levels with the labor union. In addition, termination of plan participation by one employer can increase the future benefit obligations of other employers participating in the multiemployer plan.

### (B) COLLECTIVELY BARGAINED PENSION BENEFITS

Another means of characterizing pension plans is to differentiate between those covering nonunion employees and those covering employees whose pension benefits are collectively bargained. Collectively bargained plans may be either single employer or multiemployer plans, but tend to have certain common characteristics. The design of pension benefits offered unilaterally to nonunionized employees vary to a greater degree, reflecting the different interests and needs of the work force as well as the increased freedom of an employer to choose the type of plan that best serves its own needs.

The typical mix of collectively bargained pension benefits is influenced by the nature of the labor-intensive industries in which they are commonly found. Hence they are subject, both in design and continued operation, to forces which differ from those affecting other pension plans. A recent analysis of pension provisions in collective bargaining agreements indicates that the typical plan provides for normal retirement at age 65, with nearly one-third of the plans also stipulating a compulsory retirement age. Most such plans are noncontributory and, therefore, are funded entirely by the employer. The lack of cost-of-living increases in the typical plan is partially offset by the fact that few collectively bargained plans are integrated with social security. Employees are almost always permitted to exercise early retirement options, and generally are entitled to some form of pension benefit if forced to retire due to a total or partial disability. Approximately one-third of the plans included in the survey are multiemployer plans, while 44 percent of the remainder use benefit formulas which guarantee a flat dollar amount each month per year of service. Only 15 percent of these flat-rate plans vary the monthly benefit according to base rates or separate classifications.[9]

---

[9] BNA Pension Reporter, vol. 10, No. 442, pp. 782–3. The study was based on a survey of 400 contracts chosen to represent a cross-section of bargained agreements. The analysis is based on 193 plans (61 multiemployer) for which sufficient detail was available.

### (C) SOCIAL SECURITY AND PRIVATE PENSIONS[10]

The most direct linkage between private pensions and social security is through pension integration. Statistics on pension integration conflict, but it is safe to say that more than one-third of all pension plans are integrated in some fashion with social security. Integration gives recognition to the value of employer contributions made to social security. IRS guidelines permit employers to take the value of these contributions into account in structuring pension plans.

Generally speaking, since social security benefits are based only on earnings up to the social security wage base, employers may provide pension contributions on earnings above this level without having to provide the same contributions on earnings below it, provided that the combined social security and pension benefit does not favor the more highly paid. Alternatively, employers may develop a formula for determining pension benefits which takes into account the employee's benefit from social security. Because social security benefits are weighted in favor of the lower paid, pension integration permits the plan to counterweight or tilt its benefits in favor of the higher paid. Thus integrated pension plans give higher paid workers a better pension benefit to offset the lower replacement rate they receive through social security. In addition, pension integration helps reduce the cost of the plan for providers, in part compensating for the employer's payment of social security taxes on behalf of the worker.

Pension integration formulas use either an offset or an excess method for coordinating pensions with social security. Under the offset method, a plan may incorporate a proportion of an individual's social security benefit in computing the benefit that will be provided by the pension plan. Offsets are found only in defined benefit plans. The excess method of integration provides a higher pension benefit or contribution in regard to earnings above the plan's integration level than it does in regard to earnings below it. A pure excess method pays pension benefits only for earnings in excess of the integration level. A step-rate excess formula pays benefits at a higher rate on earnings above the level taxed for social security. Excess methods are used in both money purchase and earnings-related plans.

In money-purchase plans, contributions are made to the plan either exclusively—or at a higher rate—for earnings above the integration level, which may be the social security taxable wage base for the year of contribution ($37,800 in 1984). In earnings-related plans, pension benefits may be calculated as either a set percentage of earnings above the integration level or as a combination of a lower proportion of earnings below the integration level and a higher proportion above. In this case, the integration level is the social security "covered compensation," which is the average of the taxable wage base in the years in which earnings were counted.

---

[10] For a more extensive discussion of the linkages between social security and private pensions, see an information paper prepared for the Senate Special Committee on Aging by Dr. Bradley R. Schiller and Dr. Donald C. Snyder. Linkages Between Private Pensions and Social Security Reform, 1982. This section also draws heavily on McGill, Dan N., Fundamentals of Private Pensions. Homewood, Richard D. Irwin, Inc., 1979, chap.10.

Flat-rate plans paying benefits which are not related to a worker's earnings are not integrated with social security. There is little need for integration in most flat-rate plans since participants in these plans usually have little variation in earnings.

Both offset and excess formulas are strictly controlled by antidiscrimination provisions in the Internal Revenue Code designed to prevent pension plans from using integration to divert plan assets unfairly to supervisory and more highly compensated employees. Offset plans are not allowed to reduce pension benefits dollar-for-dollar for social security benefits. The maximum reduction is set at 83⅓ percent. In practice, however, plans rarely employ more than a 50-percent reduction—a $1 reduction in pension benefits for every $2 in social security. Plans using pure excess methods may not pay or contribute more than a specified proportion of earnings above the integration level. Plans using step-rate excess methods may not exceed a maximum specified difference between rates paid for earnings below and above the earnings level. The difference in benefits may not be more than 37½ percent; the difference in contributions may not be more than 7 percent.

Pension integration, where it applies, is an important factor intervening in the effects that social security benefit changes have on retirement income. For workers participating in plans with direct offsets, a reduction in social security benefits is partially compensated for by an increase in pension benefits. As a result, these workers have a retirement income which is insulated in part from social security changes. The retirement income of workers participating in plans which use an excess method is not insulated from changes in social security benefits, and can be affected by changes in the social security taxable wage level. In principle, because this level is now indexed for wage increases, it should move in tandem with workers' earnings and have no effect on pension benefits. In practice, however, employers may select any integration level which is not higher than the taxable wage level or "covered compensation," and many plans do use a lower level with a periodic revision of the level. Where workers' earnings rise more rapidly than integration levels, increasing proportions of those earnings are being subject to a higher contribution or benefit rate. As a result, workers participating in excess plans may find their real pension benefits rising as a result of integration.

The importance of integration as insulation against social security benefit reductions should not be exaggerated. Direct offsets share the costs of social security benefit reductions between plan sponsors and participants, with neither one being fully insulated against such changes. In addition, direct offsets appear to pertain to only one in three pension plan participants, and only one in six labor force participants over age 25. If these figures are still accurate, most adult workers have no insulation of any kind in their pensions against reductions in social security benefits.

## 3. THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

### (A) ORIGINS [11]

Prior to 1974, private pension growth had taken place in largely unregulated environments. Early restrictions on private plans were developed primarily through the Internal Revenue Code, and were aimed at preventing employers from using plans only for tax advantages and diverting plan assets and income to their exclusive use. The Revenue Act of 1942 provided special tax advantages for qualified plans and required, as a condition for qualification, that plans not discriminate in their coverage, benefits, and financing in favor of supervisors, highly paid employees, officers, and shareholders. Regulations and rulings of the IRS over the next 12 years added further detail to the requirements for plan qualification to protect general employee interests and prevent misuse of pension plans as tax shelters. Revision of the Internal Revenue Code in 1954 left these requirements in place. Prior to 1974, however, there were no provisions in the code to require adequate funding of pension plans, to guarantee pension benefits, to enforce individual participants' rights to benefits, or to establish standards for plan administration and management of plan assets.

During the 1950's, as private pensions assumed rapidly increasing responsibility for providing retirement income, concern began to mount about pension plan abuses. Complaints surfaced about losses of benefits by employees after long years of service because of company mergers, plant closings, employer bankruptcies, and unemployment. Stringent age and service requirements prevented many loyal workers from receiving pension benefits when they voluntarily or involuntarily retired before the plan's eligibility age. In addition, there was growing evidence of fraud, embezzlement, and mismanagement in the investment of pension funds.

In response to these problems, Congress moved to increase protection of the rights of individual participants and reduce plan assets mismanagement by enacting the Welfare and Pension Plans Disclosure Act of 1958. This act placed primary responsibility for monitoring plan activity in the hands of plan participants themselves. Plan administrators were required to make copies of the plan and annual reports available to plan participants. Participants were expected to spot fraudulent or criminal activity through the annual report, and bring action under State or Federal laws to protect plan assets. Even though the burden for investigation and enforcement was shifted from plan participants to the Departments of Justice and Labor in the 1962 amendments to the act, the law continued to provide inadequate protection for the rights of individual participants.

Continuing pension plan abuses led to the establishment of the President's Committee on Corporate Pension Funds which released its report in 1965. In its report, the committee recommended that Federal standards be imposed on private pension plans. In particular, the committee recommended the development of mandatory minimum vesting and funding standards, and concluded that a pension plan termination insurance program, and a mechanism for portability of pension benefits were worthy of serious study. The release of this report led to the introduction of the Pension Benefit Security Act in Congress in 1968. This bill and other pension reform bills were introduced in successive sessions of Congress until finally the Employee Retirement Income Security Act (ERISA) was enacted in 1974.

---

[11] McGill, Dan N. Fundamentals of Private Pensions. 4th edition. Homewood, Richard D. Irwin, Inc., 1979. pp. 30-37.

### (B) MAJOR PROVISIONS

ERISA is one of the most lengthy and complex pieces of legislation to be enacted in recent years. The primary intent of this act is to protect the pension and welfare benefit rights of workers and beneficiaries. It addresses this goal through nine sets of provisions:

(a) *Participation provisions:* These provisions limit the age and service requirements for eligibility for participation in a pension plan. In general, an employee cannot be excluded from a plan on account of age and service if he is at least 25 years old and has at least 1 year of service (a period of 12 months with at least 1,000 hours of work).

(b) *Vesting, break in service, and benefit accrual provisions:* These provisions assure that employees who work for the same firm for a reasonable length of time receive some pension at retirement age.

(1) Vesting: There are three alternative standards for vesting: (i) Full vesting of 100 percent of accrued benefits after 10 years of service; (ii) graded vesting of 25 percent of accrued benefits after 5 years of service increasing by 5 percent each year for the next 5 years and 10 percent for each year thereafter, so that 100 percent vesting is attained after 15 years of covered service; (iii) graded vesting of 50 percent of accrued benefits when age and service add up to 45 years, increasing by 10 percent each year over the next 5 years.

(2) Break in service: Requires a plan to credit an employee for all service with an employer before and after a "break in service." The plan may require a specified waiting period before prebreak and postbreak service are aggregated, but must later give credit for that period. Nonvested employees may not lose credits for prebreak service until the period of absence equals the years of covered service.

(3) Benefit accrual: Establishes a standard of uniformity in rates of benefit accrual to prevent plans from accruing benefits at lower rates in early years of employment or younger ages.

(4) Portability: With the consent of employers, employees may transfer vested pension benefits tax free to an IRA and another employer upon separation from the firm.

(c) *Joint and survivor provisions:* This provision improves benefits for spouses, by requiring pension plans to offer certain workers the option of electing a 50-percent joint and survivor annuity at the initial age for early retirement or 10 years before normal retirement—in exchange for a lower pension amount. All workers must be provided this protection at the time of actual retirement unless they elect otherwise.

(d) *Funding provisions:* These provisions set standards for the funding of plans to assure that plans have the money to pay benefits when due. Plans created after ERISA were to develop full funding for benefit obligations within 30 years. Plans predating ERISA were allowed 40 years to develop full funding.

(e) *Fiduciary provisions:* These provisions set standards for the administration and management of plan funds. Plans are required to diversify their assets, and they may not buy or sell, exchange or lease property with a "party-in-interest." They may not divert plan assets or income to any other use than payment of benefits or reasonable plan administration expenses.

(f) *Reporting and disclosure provisions:* These provisions are designed to assure that employees and their beneficiaries know their rights and obligations under the plans, and to assure that Government agencies have the necessary information to enforce the law. Plans with over 100 participants are required to file detailed financial and actuarial data. Moreover, defined benefit plans must submit an audited financial statement and a certified actuarial statement. Plans with fewer than 100 participants are only required to file a simplified financial and actuarial report. All plans are required to furnish each participant and beneficiary with copies of the summary plan description and annual reports. Other statements are required when firms merge or transfer assets for a qualified plan, terminate a qualified plan, or when an employee with vested benefits terminates from a plan.

(g) *Plan termination insurance provisions:* These provisions assure that persons with vested benefits will receive a pension in the event that their defined benefit pension plan terminates with insufficient funds to pay benefits. Plan termination insurance is established through annual premiums paid by employers to a nonprofit Government corporation—the Pension Benefit Guaranty Corporation (PBGC). Single employer and multiemployer plans are treated differently under these provisions. In the original act, plan termination insurance was extended only to single employer plans. If a single employer, defined benefit plan terminates with insufficient funds, employees may qualify for a benefit of up to $1,381 a month (1982) (adjusted annually for changes in social security contributions and benefit levels). Employers terminating plans are liable for up to 30 percent of their net worth. Multiemployer plans were brought under the plan termination provisions in 1980. Under the 1980 amendments, the PBGC is required to provide financial assistance to a multiemployer plan when it becomes insolvent to enable it to pay guaranteed benefits, whether or not it terminates. Only a portion of the vested benefit in a multiemployer plan is guaranteed. In the event of insolvency or termination, the PBGC will guarantee 100 percent of the first $5 plus 75 percent of the next $15 of monthly benefits per year of service. Annual PBGC premiums for each participant are set at a higher rate for multiemployer plans than for single employer plans.

(h) *Individual retirement accounts and Keogh provisions:* ERISA provisions enabled employees not covered by a pension plan to take an annual tax deduction for contributions to an individual retirement account (IRA). ERISA set maximum IRA contribution levels at the lesser of 15 percent of compensation or $1,500 a year, and raised maximum Keogh contribution levels to the lesser of 15 percent of compensation or $7,500 a year. The Economic Recovery Tax Act of 1981 extended IRA eligibility to earners who are also covered by a pension, and raised maximum IRA and Keogh contribution levels. Individuals may contribute the lesser of 100 percent of compensation or $2,000 a year to an IRA, and the lesser of 15 percent of compensation or $15,000 a year to a Keogh plan. The Tax Equity and Fiscal Responsibility Act of 1982 basically eliminated the distinction in tax law between qualified corporate pension plans and Keogh plans for self-employed individuals. Effective in 1984, annual deductible contributions to a Keogh plan will generally be limited to 25 percent of compensation up to a maximum of $30,000.

(i) *Administration:* Administration for various provisions of the law was assigned either to the Department of Labor, the Internal Revenue Service, or the Pension Benefit Guaranty Corporation.

While ERISA dramatically increased the protection afforded for worker's pension benefits, it carefully limited its protections to workers who fulfilled conditions for participation and vesting as specified in the act. ERISA did not attempt to guarantee a pension to every worker, nor to assure that pension benefits that are received are adequate. In addition, ERISA did not attempt to provide full protection to spouses of deceased or retired workers, and it did not provide for portability of benefits other than in cases when plan sponsors chose to incorporate this option.

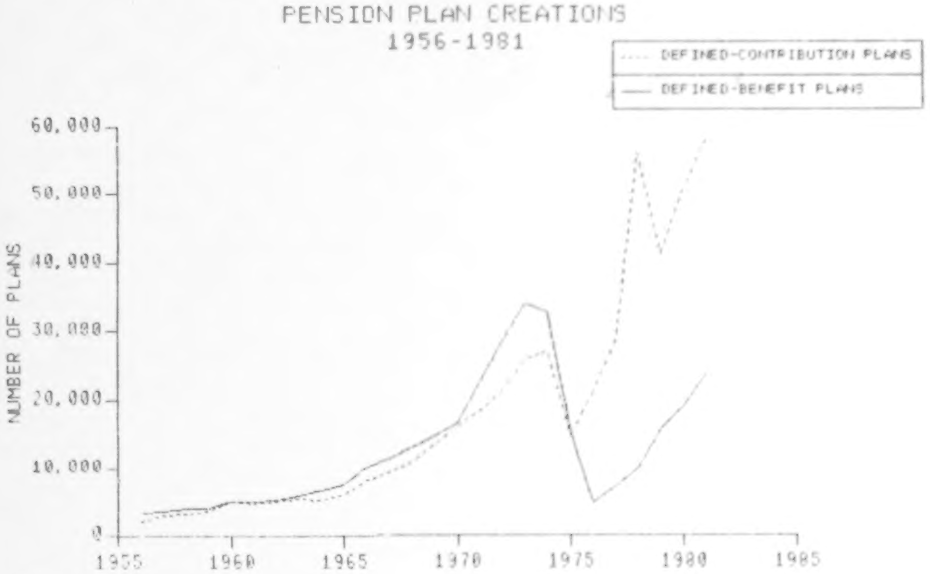
### (C) EFFECTS OF ERISA ON PRIVATE PENSION PLANS

Since the enactment of ERISA, there has been concern and controversy regarding the impact of this law on the development of pension plans, and on the nature of plan provisions. As ERISA brought into play a new set of plan standards and reporting and disclosure requirements in the pension industry, it was inevitable there would be disruption for private pension plans and added plan expenses. In retrospect, however, there is some question about how severe and long lasting this disruption has been, and whether it has had any lasting impact on the extent of pension coverage.

ERISA's most dramatic effects have been on the numbers of existing pension plans. When the law was passed, most pension plans were able to modify plan provisions and management procedures to meet standards and reporting requirements without serious disruption or excessive costs. However, many plans, particularly smaller plans, were unwilling or unable to meet the standards or the costs imposed by ERISA. In most cases these plans terminated. One interpretation of the impact of ERISA is that it weeded out the marginal pension plans—the very type of plan which led to the enactment of ERISA.

Defined benefit plans were the most directly affected, and here the numbers are startling. Prior to the enactment of ERISA the number of defined benefit plans had been rising from a low of about 5,000 net new plans a year in 1960, to a high of about 32,000 net new plans a year in 1973. In the years immediately following the enactment of ERISA, terminations of defined benefit plans tripled and creations of defined benefit plans were reduced by more than 80 percent. In 1976, there was actually a net loss of 4,000 defined benefit plans. After 1976, the number of defined benefit plans began to increase again, but by 1981, the number of annual net new plans was still only two-thirds that for 1973.[12]

CHART 3

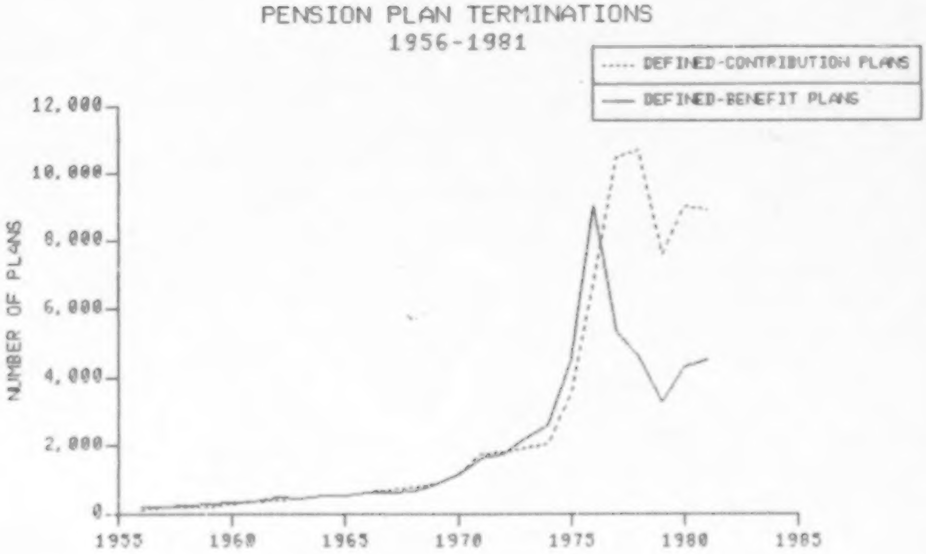

PENSION PLAN CREATIONS
1956-1981

SOURCE: Scheiber, Sylvester. "Social Security: Perspectives on Preserving the System", Employee Benefit Research Institute 1982. From IRS data.

---

[12] Schieber, Sylvester J. Social Security: Perspective on Preserving the System. Washington, D.C. Employee Benefit Research Institute, 1982, table II-2.

CHART 4



SOURCE: Scheiber, Sylvester. "Social Security: Perspectives on Preserving the System". Employee Benefit Research Institute 1982. From IRS data.

Defined contribution plans were also affected by ERISA, but only briefly. In the years immediately following the enactment of ERISA, the rate of defined contribution plan terminations rose dramatically, tripling by 1977. Plan creations, however, declined only in 1975 and 1976.[13] Overall, the enactment of ERISA has encouraged the development of defined contribution plans since these plans are not required to pay premiums to the Pension Benefit Guaranty Corporation nor to meet ERISA's funding standards. Since 1978, defined contribution plans have been created at double their pre-ERISA rate.

Not all of the post-ERISA increase in plan terminations resulted from the enactment of the law. In part, the increase was a continuation of a long-term trend of rising termination rates. Annual plan terminations rose gradually from under 300 in the 1950's to more than 2,000 by 1970, accelerating thereafter to reach nearly 5,000 by 1974.[14] A continuation of this trend, however, would only account for half of the actual post-ERISA plan terminations. Part of the increase in plan terminations could also be attributed to the occurrence in 1974 and 1975 of the most serious economic recession since World War II. It is unclear, then, how much of an impact ERISA actually had on plan terminations.

Several studies of terminating pension plans have helped to clarify the relationship between the enactment of ERISA and the increase in plan terminations. In general, these studies found the effects of ERISA to be much less severe than the previously cited statistics would indicate. Terminating plans were found to be largely small plans that did not meet the act's minimum vesting and participation standards. While ERISA may have been a major factor in many of the plan terminations, it was not the most significant factor. In many cases, the sponsor terminated one plan only to place its participants in another plan. Where participants were not transferred to another plan, in most cases they either received or were scheduled to receive all of their vested benefits.[15]

---

[13] Ibid., table II-2.
[14] Ibid., table II-2.

While ERISA may have had some impact on the development of pension plans in the short term, much of this impact resulted in a shift in emphasis in plan creations from defined benefit plans to defined contribution plans. It is clear from 1981 IRS figures that the overall growth rate for private pension plans has now exceeded pre-ERISA levels. In 1981, over 68,000 net total plans were created. In addition, while growth in pension plans was slowed by ERISA, the limitation of this impact to small plans has meant that pension coverage of the work force has remained unchanged since ERISA. In short, there is no strong evidence that ERISA is having a lasting effect on the growth in private pension plans or on pension coverage of the work force. The pension industry appears now to have adjusted successfully to the new law.

## 4. Post-ERISA Enactments and Executive Orders

### (A) MULTIEMPLOYER PENSION PLAN AMENDMENTS ACT OF 1980 (MPPAA)

One of the most difficult issues to emerge after the enactment of ERISA concerned the problem of providing plan termination insurance for multiemployer plans. Many industries with multiemployer plans have been experiencing declining employment and high rates of business failure. As a result, the funding obligations for remaining employers has been increasing substantially in some plans. When ERISA was passed in 1974, it was feared that inclusion of multiemployer plans in the plan termination insurance guarantees would enable ailing plans to immediately shift their pension burden to the Pension Benefit Guaranty Corporation (PBGC). A later PBGC study raised concern that automatic inclusion of multiemployer plans in the provisions of title IV of the act could result in the PBGC having to fund as much as $4 billion in benefits in multiemployer plans failed.[16] Although multiemployer plans were required to pay premiums from the start, insurance of benefits was delayed under the act until January 1978. In the interim, ERISA gave Pension Benefit Guaranty Corporation (PBGC) discretion to cover terminations on a case-by-case basis. This was intended to allow the PBGC to gain some experience with multiemployer plans before termination insurance coverage became mandatory. Mandatory coverage of benefits was then postponed several more times, until it finally became effective in August 1980.

---

[15] Pension Benefit Guaranty Corporation. Analysis of Single Employer Defined Benefit Terminations, 1975. (March 1976). Pension Benefit Guaranty Corporation. Annual Report. (June 1975). Pension Benefit Guaranty Corporation. Analysis of Single Employer Defined Benefit Plan Terminations, 1978. (May 1981).

U.S. General Accounting Office. Effect of the Employee Retirement Income Security Act on the Termination of Single Employer Defined Benefit Pension Plans. Report No. HRD-78-90, Apr. 27, 1978. Washington, 1978.

U.S. General Accounting Office. Effects of the Employee Retirement Income Security Act on Pension Plans with Fewer Than 100 Participants. Report No. HRD-79-56, Apr. 16, 1979. Washington, 1979.

[16] Pension Benefit Guaranty Corporation. Potential Multiemployer Plan Liabilities Under Title IV of ERISA Sept. 29, 1977.

In 1979, PBGC submitted specific recommendations to Congress for revising the multiemployer termination insurance provisions. The recommendations became the basis for the Multiemployer Pension Plan Amendments Act of 1980 (Public Law 96-364) which was signed into law in September 1980. The amendments sought to remove incentives for withdrawal, and protect remaining sponsors, by requiring that an employer withdrawing from a multiemployer plan continue to fund its fair share of the plan's total unfunded vested liability. The withdrawal liability is payable in annual installments for a period of up to 20 years.

In addition, the 1980 amendments made changes in the pension benefit insurance program to bolster ailing multiemployer plans. First, the definition of an "insurable event" was changed from plan termination to plan insolvency. Thus, the PBGC was required to provide financial assistance to insolvent multiemployer plans to enable the plans to pay benefits. Second, employers in certain financially troubled plans were protected from large increases in contributions. These plans, termed "plans in reorganization" were required to meet a minimum contribution requirement (MCR) which generally increased their funding obligations. The MCR is phased in to prevent an excessive increase in 1 year, and is reduced if the plan is "overburdened" with a high proportion of retirees. Third, trustees of financially troubled multiemployer plans were permitted to reduce or eliminate benefit increases that had been in effect for less than 5 years.

Finally, the 1980 amendments attempted to insulate the PBGC from the cost of excessive multiemployer terminations by raising the annual per participant premium paid by multiemployer plans and specifying a limited benefit guarantee level for these plans. Retirees or those participants within 3 years of retirement were assured full guarantee of their pension benefits. For others the PBGC guaranteed 100 percent of the first $5 of monthly benefits per year of service, plus 75 percent of the next $15 of monthly benefits per year service.

### (B) REORGANIZATION PLAN NO. 4

Initial problems of overlapping jurisdictions between the Departments of Treasury and Labor and the PBGC led to complaints of redundant and excessive paperwork, backlogs of unprocessed applications for administrative exemptions from prohibited transactions, and delays in the issuance of regulations. In 1978, in response to these complaints, President Carter issued reorganization plan No. 4 which eliminated much of the jurisdictional overlap resulting from ERISA. The plan assigned responsibility for each major provision of ERISA to one agency. As a result, there was a substantial reduction in the paperwork burden, processing of applications for exemptions was improved, and cooperative agreements between Labor and Treasury were begun to improve coordination of the field activities of these agencies.

## (C) TAX EQUITY AND FISCAL RESPONSIBILITY ACT OF 1982 (TEFRA)

### *(1) Background*

Congress made the most far-reaching changes in the tax provisions affecting employee benefit plans since the enactment of ERISA as part of the Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248). These changes included reducing the amount of tax deductible contributions that may be made to corporate pension plans and eliminating the distinctions between corporate and noncorporate plans.

In general, the motivation for the pension provisions in TEFRA was to eliminate the pension tax incentives for incorporation, and the resultant opportunities in pension tax law to voluntarily shelter income in excess of that needed for retirement. The focus on professional service organizations arose from concern that the indexing of benefit/contribution limits in corporate pension plans was encouraging professionals to incorporate to take advantage of the greater tax deductible pension accumulations permitted in corporate pension plans than in Keogh plans for the self-employed.

### *(2) Provisions*

#### *(a) Limits on contributions and benefits*

The Tax Equity and Fiscal Responsibility Act of 1982 made several changes in the overall limits on pension plan contributions and benefits. The maximum dollar limits on pension contribution and benefits were reduced. The maximum dollar limit on annual additions under defined contribution plans was changed from the lesser of 25 percent of compensation or $45,475, to the lesser of 25 percent of compensation or $30,000. The maximum dollar limit on the annual benefit payable under defined benefit plans was changed from the lesser of 100 percent of compensation or $136,425, to the lesser of 100 percent of compensation or $90,000. If retirement benefits under a defined benefit plan begin before age 62, the $90,000 limitation is reduced so that it is the actuarial equivalent of an annual benefit of $90,000 beginning at age 62. However, it will not be less than $75,000 at age 55. These limits are frozen until 1986, when automatic adjustments for price inflation are to resume. Reductions were made in the overall limits allowable in a case where an individual is covered by both a defined benefit plan and a defined contribution plan. Transitional rules will insure that benefits already earned under existing plans are not reduced because of the lower contribution and benefit limits.

#### *(b) Parity between corporate and noncorporate plans*

The Tax Equity and Fiscal Responsibility Act established parity between corporate and noncorporate plans. Special rules for Keogh plans for the self-employed were repealed to place them on equal footing with corporate plans, including the $30,000 contribution and $90,000 benefit limitations.

### *(c) Top heavy rules*

Stricter rules were established for so-called "top heavy" plans. A top heavy plan is defined as a plan under which more than 60 percent of the accrued benefits (or contributions) are provided for key employees. A key employee is defined as an officer, a 5-percent owner, a 1-percent owner with compensation in excess of $150,000, or the employees owning the 10 largest interests in the employer.

Special requirements for top heavy plans include accelerated vesting schedules and a minimum benefit. Full vesting will be required after 3 years' service, or, alternatively, graded vesting beginning with 20 percent after 2 years' service increasing by 20 percent each year so that 100 percent vesting is attained at the end of 6 years' service. The minimum benefit required of a top heavy plan will be 2 percent of pay multiplied by the employee's years of service (not to exceed 20 percent) in a defined benefit plan. A contribution of 3 percent of pay will be required in a defined contribution plan, or if less, the highest contribution rate for any key employee.

### *(d) Pension integration*

With regard to integration of defined contribution plans with social security, the credit for all such plans—corporate and noncorporate—will be reduced from 7 percent to the statutory OASDI tax rate, currently 5.4 percent.

### *(e) Loans to participants*

Generally, loans from a tax-qualified or governmental pension plan will be treated for Federal income tax purposes as a plan distribution to the extent the loan exceeds prescribed limits. All loans up to $10,000, plus those loans up to $50,000 that do not exceed half of the present value of an employee's vested benefits, will not be treated as a distribution provided that the terms of the loans call for repayment within 5 years. If a loan is in connection with a principal residence of the participant or a family member, however, it will not be subject to the 5-year repayment rule; instead, a "reasonable" repayment schedule will be allowed.

### *(f) Other changes*

Other employee benefit changes include a limit on the Federal estate tax exclusion for employer-provided benefits paid from qualified plans to $100,000 for deaths occurring after December 31, 1982. (The exclusion was previously unlimited.) The act also required income tax to be withheld from all taxable pensions and annuities including lump-sum distributions—unless the recipient elects not to have taxes withheld. This election would remain in effect until the recipient revoked it. However, starting in 1983, a payer will have to provide recipients with annual notice of their rights to make, renew, or revoke an election.

## 5. Private Pension Issues and Legislation—1983

### (A) PENSION COVERAGE AND ADEQUACY

In February 1981, the President's Commission on Pension Policy issued its final report on retirement income problems and policy recommendations, entitled "Coming of Age: Toward a National Retirement Income Policy." The recommendations dealt in large part with efforts to strengthen private pensions. They focused on problems with pension coverage, inadequacy of pension benefits, lack of coordination with other income programs, erosion of benefits due to inflation, and gaps in pension coverage for women. The principal recommendation of the Commission was the formation of a mandatory universal pension system (MUPS) for all workers.

The privately sponsored Committee for Economic Development released its own report in 1981, entitled "Reforming Retirement Policies," which served as a counterpoint to the President's Commission recommendation for mandatory pension coverage. The committee suggested that employer pensions could be improved and coverage expanded through the continued use of tax and regulatory incentives.

Many of the issues addressed by the Commission and committee have yet to be fully considered in Congress. Among the issues now receiving increased attention, however, are women's pension equity and pension accruals after age 65.

### *(1) Pension Protection for Women*

The President's Commission emphasized two areas where women experience particular problems in gaining adequate pension protection. First, women in the work force typically have lower rates of coverage than men. Second, women who are spouses of covered workers face gaps in pension protection when widowed or divorced. For whatever reason, poverty among the elderly is predominantly the poverty of older women, and it is principally this failure to qualify for pension benefits which draws that line. As has been the case since the original considerations of ERISA, perennial legislative initiatives were introduced in 1983 addressing these concerns by Senators Durenberger and Packwood.

#### *(a) The Retirement Equity Act*

The emergence of the so-called gender gap in 1983 sparked Senate leadership interest in pension equity, which culminated in Senator Dole introducing the Retirement Equity Act (originally S. 1978, attached to H.R. 2769). After a whirlwind consideration by the Senate Finance Committee, H.R. 2769 passed the Senate in the closing hours of the session. The House bill (H.R. 4280), virtually identical to H.R. 2769, was approved by the Education and Labor Committee, but did not progress further before the end of 1983. Passage of some form of pension equity legislation is expected during 1984.

The pension accrued by the working spouse is often the single largest asset of an older married couple. Its importance both to the employed and nonemployed spouse cannot be underestimated. However, many married women who choose to work in the home can be deprived of this income by a variety of circumstances including death or disablement of the employed spouse, or divorce. The general philosophy behind the various equity bills is to recognize that the retirement benefit is a jointly owned asset of the married couple as partners. For older women, the most significant provisions of the Retirement Equity Act (H.R. 2769) pertain to women as nonemployed spouses.

The main issue is that of joint and survivor coverage. The joint and survivor annuity is an amount equal to the vested benefit of the employee, actuarially reduced to take into account the potential early starting date and extended length of payments. Under current law, mandatory joint and survivor coverage is not provided until the employee reaches regular retirement age (usually 65). The employee may elect such coverage at the firm's early retirement age (or age 62, whichever is later), but if he takes no affirmative action, there is no survivor coverage until the employee reaches 65.

Consequently, many dependent spouses have found that they are not entitled to benefits under their spouse's retirement plan, regardless of his years of service, simply because he (or she) died 5 years, 5 months, or 5 hours too soon. In other cases, because the employed spouse alone makes the decision as to whether to receive the retirement annuity on a joint and survivor basis, a number of surviving spouses have been surprised to find that benefits ceased with the death of the retired employee, even though they had been told, or had assumed, that some benefit would continue through their lives as well.

The Retirement Equity Act mandates that any plan providing a life annuity (even as an option) must provide it in the form of a joint and survivor benefit, unless the employee elects out of that provision. The Senate bill also proposes to provide benefits to a surviving spouse at a much younger age. If a disabled or deceased employee has reached age 45 with 10 years of vested service, then the spouse must be provided with an automatic benefit unless the couple previously waived the provision. Finally, in order to waive new automatic survivor coverage, the working spouse must obtain the written consent of his spouse. (Under present law, an employee is not required even to notify his spouse of the options.)

In addition to addressing the problems encountered by spouses who are dependent upon the pension of an employed spouse, H.R. 2769 seeks to remedy some of the difficulties which are encountered by women earning pensions in their own right.

ERISA standards reward a particular kind of employee: one whose service is long term, uninterrupted, and highly compensated. Very often the work histories of women, as primary family caretakers, do not fit into this mold. If they do work, their employment is in addition to traditional family obligations. They incur breaks in service for childbirth and child rearing. Finally, women tend to work in lower compensated jobs, and in fields which do not provide adequate pension coverage.

For women who are or will participate in the work force, H.R. 2769 contains provisions intended to increase pension accruals. The bill proposes to lower the minimum age for participation and vesting to 21 and 18 (from 25 and 22), respectively, in order to allow women to accrue credits early in their worklife. Fully 68 percent of all women between ages 19 and 24 work full time, after which period many leave the job market, if temporarily, to assume family responsibilities.

Break in service and maternity/paternity leave rules would also become more flexible under H.R. 2769. Plan participants, whether vested or not, would not incur a break in service for such leave, and would neither lose prior credits nor receive additional credits for the period of absence. In addition, employees with less than 5 years of credited service would not lose credit for those years due to a break in service of up to 5 years, for whatever reason, providing they return to the same employer.

Finally, H.R. 2769 addresses the status of a divorced spouse's interest in a former spouse's pension assets. ERISA provisions prohibiting the alienation of pension benefits have been interpreted by some State courts as prohibiting the division of pension benefits pursuant to a valid domestic relations order. H.R. 2769 expressly exempts such orders from ERISA's antiassignment/alienation rules, providing that the order is "qualified" according to the terms specified in the bill. To encourage recipients to treat such distributions as retirement income, it provides that lump-sum distributions made pursuant to a domestic relations settlement may be rolled over into a tax-deferred individual retirement account.

Despite the expected passage of pension equity legislation early in the second session of the 98th Congress, there remain several continuing issues in the pursuit of enhanced retirement benefits for women. Many experts anticipate rising work force participation among women. Accordingly, future legislation should be designed to improve the benefits available to employed women by refining ERISA, the Tax Code, and social security law. Numerous bills have been introduced suggesting that earnings sharing be implemented in social security so that working couples receive benefits which reflect their combined income. At present, social security provides an enhanced benefit for married couples based on the highest earnings of one or the other partner. Owing to her work history, the wife's benefit is often lower than the husband's. The benefit she receives based on her husband's income is greater than that which she would receive based on her own employment. Earnings sharing would average the income of the couple on a yearly basis and provide a social security benefit to each partner based on that average. Such proposals generally include a phasing out of the dependent spouse's benefit.

### *(b) Sex neutral actuarial tables*

Another controversial issue, which is not addressed in the Pension Equity Act (H.R. 2769) is the use of unisex actuarial tables in the pension and insurance industries. Insurance companies traditionally have used sex-based tables to determine pension benefits and costs, as well as life, health, and auto insurance rates. The use of sex-differentiated tables results in assessing different costs and benefits to equally situated persons of opposite sexes. For the purposes of pensions, the statistically longer life expectancy of women means any monthly annuity provided to a woman is reduced to reflect the cost of providing that benefit over a longer period of time. Conversely, holding the monthly benefits equal, the cost of providing a monthly annuity is higher for a woman if sex-based tables are used.

In June 1983, the U.S. Supreme Court mandated in *Norris* v. *Arizona Governing Committee* that unisex tables be used in determining benefits paid by a voluntary deferred compensation plan for

Arizona State employees. The retirement plan which was the subject of the *Norris* case allowed employees to defer a portion of their income in exchange for several options, including a life annuity at retirement; however, the monthly annuity payments to women under the plan were lower than those to similarly situated men. The decision was foreshadowed by a 1978 case, *Los Angeles* v. *Manhart,* which prohibited the use of sex-based tables in a mandatory retirement plan which required women to pay larger contributions than men in order receive the same benefit.

The Supreme Court's decision in *Norris* was restricted to employer-employee relationships. The option to use sex-based tables remains open to private insurers. This option lead to two interrelated concerns. First, many employers currently offer their employees the option of receiving annuities or lump-sum distributions of their benefit. Since private insurers are able to offer sex-based figures, annuities provided to men by private insurers could be higher than the annuities they would be able to receive from their employers, thus leading to a larger percentage of male employees opting for the lump-sum distribution and private arrangements.

Concurrently, since female employees would not benefit by going to a private insurer, they would likely opt to receive an annuity from their employer. But, the exodus of male participants will drive up the cost of providing these annuities to employees remaining in the annuity plan. In order to curb costs, employers might well decide not to offer an annuity option at all, forcing more employees to private insurers, where sex-differentiated tables are still used.

Legislation is now before Congress which would require private insurers to use sex-neutral actuarial tables as well. The Fair Insurance Act (S. 372, H.R. 100) received initial hearings in the Senate and House of Representatives, but its progress was stalled pending a General Accounting Office (GAO) study of the costs to the insurance industry of implementing the proposal. Further consideration of the bills may be taken up during the second session of the 98th Congress.

### *(2) Pension Accruals After Age 65*

A vital issue still facing older workers is how to expand their employment opportunities. Of the several obstacles to continued employment of persons aged 65 and over, one of the most important work disincentives may be the lack of credited benefit accruals in more than one-third of all private pension plans.[17] Under agency interpretation of ERISA and the 1978 Amendments to the Age Discrimination in Employment Act (ADEA), mandatory retirement is generally prohibited prior to age 70, and employers must maintain coverage under fringe benefit plans for workers over age 65. However, pension benefits have been exempted from this requirement, and employers are permitted to cease contributions to pension plans at normal retirement age; not credit years of service, salary increases, or benefit improvements; and not increase benefits payable at retirement to take into account the delayed starting date of benefit payments due to continued employment.

---

[17] See also, chap. 6, Employment.

Unlike special early retirement options, sometimes referred to as "window plans" or "one shot" retirement incentives, the discontinuation of pension accruals is not a positive inducement to retirement, but a disincentive to continued employment. Employers view the discontinuation of pension accruals as a tool to control the composition of their work force, lower the cost of contributions for employee benefits, and make room for promotions and new hires. It also serves to help fund the pension plan, because the employee choosing to continue working beyond age 65 will draw fewer years of retirement benefits from the plan without any corresponding increase in the amount of the periodic benefit received. Since an employer's salary and pension costs are typically higher for older workers, unless an older worker's productivity is correspondingly higher than that of younger workers, the employer has a financial incentive to discourage his or her continued employment beyond age 65.

On September 15, 1983, the Equal Employment Opportunity Commission (EEOC) formally requested comments on the practice of discontinuing contributions and service credit at age 65. Employees consider their pensions part of their total wage/compensation package. To them, discontinuation of pension accruals is tantamount to a unilateral discriminatory wage reduction solely on account of their age. Although the number of employees who would be affected by a change in the rule is small relative to the size of the total work force, a discontinuation of pension accruals can substantially reduce the benefits eventually received by those affected, possibly undermining the adequacy of their total retirement income. The elimination of the present exemption would require employers to use retirement incentives, rather than disincentives to continued employment, to control the composition of their work force, enhancing the retirement income of those accepting such options.

### *(3) Inflation Protection*

In contrast to social security benefits, which are automatically adjusted each year for increases in the Consumer Price Index (CPI), the benefits received by most private pension participants do not include provisions granting full cost-of-living adjustments (COLA's). The more common practice among private pension sponsors is to grant ad hoc increases in retirees' annuities. Some employers have shown interest in supplemental pension arrangements that grow at a predetermined rate over some or all of the employee's retirement years, but these so-called "escalator annuities" generally involve cost sharing between the employer and employee. With no inflation protection at all, a 10-percent inflation rate would cut the purchasing power of a retirement benefit in half in only 7 years. A Labor Department study determined that even with ad hoc inflation adjustments, the real value of pension benefits decreased at an average yearly rate of 4 to 8 percent in the early 1970's.[18]

---

[18] Horst, Robert L., Jr., and Donald E. Wise. Private Pension Benefits and the Rate of Inflation. Math Tech, Inc., May 1979.

The effect of inflation on the purchasing power of a retiree's total retirement income is dependent on the mix of income sources available to the individual. A report published by Towers, Perrin, Forster, & Crosby suggests that while inflation is a serious problem, not all retirees suffer irrevocable erosion of purchasing power throughout their lives. According to the study, most retirees experience some decrease in purchasing power in the first few years of retirement, but so long as social security benefits remain indexed to the CPI, social security COLA's will tend to offset the effects of inflation on a retiree's pension benefit. If, as the report contends, the CPI overstates inflation by 2 to 5 percent annually, then those retirees whose incomes consist of at least 70 percent social security benefits would experience a gradual increase in real income as the CPI-COLA's overcompensate for inflation.[19]

Assuming that a retirement benefit is adequate at the time an employee retires, for most, the principal effect of inflation is to threaten a slow decline in purchasing power after retirement. However, inflation can impair retirement income security even before retirement if the formula used to calculate benefits does not make adequate allowances for its erosive effects.

Many employees are covered by plans which calculate benefits based on salary levels, either averaging career earnings or earnings during some specified period of highest compensation. Since salary tends to increase with inflation as well as promotion and cumulative service, benefit formulas based on the employee's highest years of compensation provide the best protection against inflation, while career average benefit formulas provide less effective insulation. But many collectively bargained plans simply provide benefits based on a fixed amount each month per year of service, regardless of the employee's salary level. Such plans require continuous ad hoc adjustments of the fixed benefit to insure that inflation will not erode the basic adequacy of the benefit by the time the employee reaches retirement age. Social security benefits may play some role in mitigating this effect, as preretirement indexing is designed to offset the effects of inflation in the same manner that postretirement COLA's offset inflation once social security payments begin. For employees covered by flat-rate plans, the degree to which inflation will erode the adequacy of future retirement benefits will be a function of the proportion of their social security benefits to their total income.

### (B) PLAN TERMINATIONS AND PBGC BENEFIT GUARANTEES

Once Congress enacted the Multiemployer Pension Plan Amendments Act in 1980, attention was gradually focused on the need to reexamine single employer termination procedures under ERISA. In its present form, substantial financial incentives exist for some plan sponsors to terminate their defined benefit plans independent of any considerations relating to the best interests of plan participants. In 1983, Congress continued the extensive process of examining abusive pension plan terminations in an effort to close loopholes in the current fabric of ERISA.

---

[19] Towers, Perrin, Forster, & Crosby, Special Report. Pensioner Cost-Of-Living Increases: Who Needs Them?, 1981.

With the emergence of several additional pension issues, the multiemployer termination insurance program received less congressional consideration during 1983 than in recent years. The most significant development may have come in the form of continuing legal challenges to the constitutionality of MPPAA's retroactive effective date. The Supreme Court is expected to address the issue sometime during 1984.

### *(1) Single Employer Termination Insurance Program*

The recent recession, coupled with the general decline of major industries in the United States, has severely stressed many employers, precipitating bankruptcies and causing the termination of several large pension plans. The growing number of terminated plans which have insufficient assets to pay accrued vested benefits has placed a burden on employees, employers, and the PBGC termination insurance program. Unfortunately, the situation has been worsened by plan terminations that were not necessitated by business failures, but represent attempts by irresponsible employers to take advantage of termination insurance guarantees and escape liability for unfunded accrued pension benefits by terminating the plan and dumping the liability on PBGC.

#### *(a) Detrimental effects of abusive plan terminations*

Any plan termination represents a potential threat to an employee's retirement income security. Even though vested benefits are generally insured by the PBGC, the termination insurance program does not guarantee all accrued benefits, setting limits on the maximum benefit payable. While an employee covered by the termination insurance program is protected from having his or her entire pension wiped out by the termination of a plan which proves to have insufficient assets to pay plan liabilities, the difference between accrued benefits and guaranteed benefits may have a significant impact on the employee's retirement income. Similarly, the absence of a defined benefit plan in the future, or the replacement of the old plan with a new one which provides less generous benefits, means that the employee will receive a smaller monthly retirement benefit than expected. It is therefore usually in the interest of employees for the employer to resist terminating an underfunded pension plan unless the failure to do so would cause bankruptcy.

It is also in the interest of other plan sponsors for those terminations to occur only as a result of business necessity. At present, the PBGC termination insurance program is funded by a flat rate (per employee) premium paid by plan sponsors to PBGC, rather than by a risk/related premium as is ordinarily paid to private insurers. The PBGC termination insurance program is therefore not a true insurance system, but an indirect means of distributing the cost of unfunded liabilities of terminating plans among remaining employers. To the extent a particular termination is not motivated by business necessity, the program essentially requires responsible employers to subsidize the unfunded pension liabilities of less responsible employers.

Abusive terminations designed to dump pension liabilities on the termination insurance program can also have a serious detrimental impact on the continuing solvency of the PBGC. Already strained by terminations that have resulted from a flagging economy, abusive terminations threaten to worsen the PBGC's already serious deficit. Although the PBGC has a claim against an employer terminating an "underfunded" pension plan for one-third of the employer's net worth, unfunded plan liabilities frequently exceed this amount. In these circumstances an employer still has a financial incentive to terminate the plan, and the PBGC cannot under current law proceed to collect from the employer the full value of guaranteed benefits paid.

### *(b) PBGC premium rate increase request*

At the close of fiscal year 1982, the PBGC reported a deficit of $333 million due to insurance claims from terminating plans which were accumulating faster than they could be financed by the collection of insurance premiums from plan sponsors. The PBGC estimated that unless premiums were increased, the deficit could reach $938 million by fiscal year 1987.

The PBGC's single employer termination insurance program is financed primary from premiums collected from plan sponsors of ongoing plans, based on the number of plan participants. The annual premium rate, originally set at $1 per plan participant in 1974, when the program was created, was quickly raised to $2.60 by Congress in 1978. The annual premium rate has not increased since then, but a request was made in May 1982, to raise the premium to $6. A report issued by the General Accounting Office (GAO), entitled "Legislative Changes Needed To Financially Strengthen Single Employer Pension Plan Insurance Program" (November 14, 1983), found the proposed rate increase to be reasonable and necessary to reduce the deficit at this time. However, the report also criticized PBGC for not acting on past premium rate studies which indicated the need for an increase. It recommended that PBGC act in a more timely manner to advise Congress of changes needed in its premium rate.

The premium rate increase request is now pending before Congress as part of the administration's single employer reform bill in the Senate (S. 1227), as well as a compromise reform bill introduced by Representatives Clay and Erlenborn in the House of Representatives (H.R. 3930). However, the PBGC request is based on an assumed January 1, 1983, effective date. If the effective date is pushed back, the $6 premium will not be sufficient to eliminate the deficit and the PBGC's long-term solvency may again be threatened.

### *(c) Single employer termination insurance reform*

Some plan sponsors have objected to the proposed rate increase, which would more than double plan sponsors' premium costs. There has been strong opposition from private pension sponsors to any increase in the premium rate until those weaknesses in the present single employer termination insurance program can be eliminated. In May 1983, Senator Nickles introduced a bill on behalf of the administration (S. 1227) which incorporates the recommendations of a joint agency task force set up in November 1982, and seeks to limit the ability of employers to terminate plans which have insufficient assets to pay accrued benefits, transferring their unfunded liabilities to the PBGC.

The administration bill (S. 1227) would permit a plan sponsor to terminate an underfunded pension plan only when the employer could prove that continuation of the plan would precipitate bankruptcy. It also imposes contingent liability on employers for the funding deficiency of a plan following a transfer of the business or the "spinoff" of a subsidiary corporation. Under an agreement between PBGC and the IRS, PBGC currently negotiates conditions on the granting of funding deficiency waivers on a case-by-case basis with IRS and the plan sponsor. S. 1227 would permit PBGC to impose conditions on the granting of such waivers, and receive a lien to cover all plan funding contributions, with interest, outstanding at the time of termination.

Employers objected to S. 1227 because it limits the ability of plan sponsors to voluntarily terminate a pension plan without necessarily preventing abusive terminations which would dump unfunded liabilities on PBGC. In response to the concerns of employers and employees alike, a compromise bill (H.R. 3930) was prepared and introduced by Representatives Clay and Erlenborn in September 1983. Unlike S. 1227, which links the right of an employer to voluntarily terminate an insufficient plan to the threat of bankruptcy, H.R. 3930 permits an employer to voluntarily terminate a plan at any time, but effectively shifts the insurable event that triggers PBGC's benefit guarantees from plan termination to the employer's proof of financial "distress."

Under the Clay-Erlenborn proposal, PBGC benefit guarantees would be triggered if the employer demonstrates a significant "distress" situation which would threaten its continued financial viability unless relief were granted. Employers would still be permitted to freeze benefits accrued under the plan under a standard termination. However, employers would be required to count additional service after termination for vesting and eligibility purposes (termed a "shallow freeze" in current IRS practice), and to continue to fund the plan until all nonforfeitable benefits are satisfied.

The bill would make plan sponsors contingently liable for transferred plans for up to 5 years—10 in situations involving large transactions—in the event that the plan eventually terminates. PBGC would receive a lien in the amount of any funding deficiency waivers granted by the IRS, and the amount for which an employer is liable is increased from 30 percent of net worth, as under present law, to 10 percent of pretax profits for 10 years following the termination. An additional amount equal to 5 percent of pretax profits would be payable to a termination trust providing for the payment of nonforfeitable benefits which exceed the current limits on benefits guaranteed by PBGC.

The most controversial provision in H.R. 3930 is the inclusion of a so-called union veto. A plan administrator would be prohibited from filing a notice of intent to terminate a plan which is subject to a collective bargaining agreement if objection is voiced by the employee organization representing plan participants. Some Members of Congress have opposed the "union veto" because it grants to a union a right which ordinarily would have to be bargained for.

The inclusion of this provision in particular makes the enactment of the bill during 1984 uncertain. It was favorably reported by the Subcommittee on Labor-Management Relations to the House Committee on Education and Labor in October, but failed to progress any further before the close of the first session. H.R. 3930 was also referred to the House Ways and Means Committee, but the committee did not consider the bill during 1983.

### *(2) Reversion of "Surplus" Assets Upon Termination*

During recent years the termination of a well-funded defined benefit pension plan has emerged as a common technique used by employers to raise capital to meet corporate exigencies. Although some pension plans have been terminated because of the employer's insolvency or reorganization, a small but significant number of plan terminations apparently take place even though the employer is not financially distressed. Any plan termination is a potential threat to the retirement income security of participating employees, who face the danger of receiving a smaller pension benefit than they had expected, and perhaps relied on, when planning for retirement. Some Members of Congress have become concerned that these employees are being put at risk simply because their employers wish to recapture "surplus" assets from their pension plan and termination of the plan is the only means available which allows them to do so immediately.

#### *(a) How "surpluses" are created*

Employers usually contribute to their plans according to an actuarial funding method which calls for a constant contribution rate over an extended number of years. The selection of a level-funding method avoids large funding increases in later years when benefit accruals increase in value. A second result is that in the early years of the plan's existence, its assets will accumulate more rapidly than its liabilities. Therefore, the vast majority of terminated pension plans have assets equal to or in excess of their liabilities at termination.

Pension plans which are terminated and result in the reversion of "surplus" assets to the employer are often referred to as "overfunded" pension plans. This description is misleading. The use of a level-funding method itself can create a surplus, as described above, when the plan is terminated before its liabilities fully mature. Second, the plan's projected liabilities, funded on a continuation basis, take into account future service and salary increases. However, the plan's actual liabilities upon termination are limited to accrued benefits based on salary and service at the time of termination. A surplus at termination, therefore, may represent the difference between projected benefits funded on a continuation basis and actual benefits calculated and paid on a termination basis. Third, many plans are funded using conservative interest rate assumptions. Current high interest rates used to calculate annuity premiums and other termination liabilities are often substantially higher than the plan's interest assumptions used for funding purposes. Thus, the surplus may also be the result of the difference between current high interest rates available to terminating plans and the plan's lower assumed rate of return on investment. Given all of these factors, it is therefore possible for a plan which is only adequately funded, or even considerably "underfunded," when valued on a continuation basis to produce large amounts of "surplus" assets at termination.

A few terminated plans have, in fact, been "overfunded" even when valued on a continuation basis, most likely as a result of unexpectedly profitable stock market investments during the last few years. However, true surplus assets—those in excess of liabilities valued on a continuation basis—are only a portion of the amount which reverts to the employer upon plan termination. The existence of assets in excess of termination liabilities primarily reflects the funding method chosen by the employer and the interest rates used to calculate termination liabilities, rather than fortuitous fluctuations in financial markets.

### *(b) "Spinoff" terminations*

In the absence of any legislation to limit the reversion of "surplus" assets, the PBGC chose not to authorize the distribution of plan assets following certain terminations. Some plan sponsors sought to recapture "surplus" assets either by terminating their plan, recapturing the surplus and then starting up a new, comparable successor plan, or by "spinning off" active employees into a new plan with just enough assets to fund it, leaving only retirees in the old plan which is then terminated in order to recapture the surplus. These terminations are designed to permit an employer to recapture "surplus" assets while continuing to provide pension benefits to active employees by means of a defined benefit plan.

Terminations which effectively siphon assets in excess of those needed to fund ongoing liabilities have been perceived by PBGC as a potential threat to the termination insurance program. If in the future the new plan's funding deteriorates and it eventually terminates, the lost recaptured assets could be the difference between the plan's having sufficient assets to pay accrued benefits and the PBGC having to assume insurance liability for the plan's unfunded guaranteed benefits.

While PBGC's concerns may be valid, the unfortunate result of its resistance may have been to cause sponsors to terminate their plans completely, recapture the surplus, and replace them with defined contribution plans instead. As 1983 came to a close, there was some indication that PBGC might be willing to reconsider such terminations on a case-by-case basis, and negotiate what it determined to be an adequate "cushion" in the successor plan to prevent the plan from eventually becoming "underfunded" and transferring liability to the PBGC.

### *(c) Detrimental effects of plan terminations*

Some pension experts and Members of Congress have expressed concern that current law and agency regulations do not adequately protect the interest of plan participants when their defined benefit plan is terminated. While employees who receive annuities (to satisfy the plan's obligation to satisfy all plan liabilities before reversion can take place) are guaranteed they will receive the full value of their accrued benefits to the date of termination, they will receive a smaller benefit than expected at retirement unless the terminated plan is replaced by a new plan which offers equal or greater benefits. Employees receiving mandatory lump-sum distributions of their accrued benefits, however, are in danger of not even receiving the true present value of their accrued benefits.

Under the current PBGC regulations, an employer is permitted to calculate lump-sum distributions of the present value of accrued benefits with the same interest rate used to calculate the premium paid for annuities purchased to satisfy plan liabilities. A high annuity interest rate assumption will decrease the premium paid by the terminating plan to purchase annuities, so employers have a financial incentive to purchase annuities with the highest available interest rate. The high interest rate will also decrease the size of lump-sum payments to employees when used to calculate mandatory cash-outs, however, again giving employers a financial incentive to use the highest available interest rate to maximize the amount of assets remaining which will eventually revert to the employer.

If employees are to receive the true present value of their accrued benefits, then the lump-sum distribution must be large enough to permit the employee to invest it so that it will equal the full value of the employee's benefit at retirement. In some instances, the use of very high annuity interest rates to calculate lump-sum payments has made it increasingly difficult for plan participants to invest the lump sum in a manner which will provide a return high enough to generate the full value of their accrued benefits.

Plan terminations in anticipation of a revision of assets have a destabilizing effect on the private pension system. Plan sponsors have interpreted current law as permitting them to terminate a plan for any reason at any time. If this interpretation is correct, then employers can essentially use their pension plans as a reservoir of capital to be reclaimed when convenient in spite of the interests of participating employees. Under these circumstances employers have a strong financial incentive to terminate a well-funded defined benefit plan. Companies with well-funded pension plans can become takeover targets for the same reason. After a successful takeover, the acquiring corporation can terminate the acquired corporation's defined benefit plan and use the reversion to help defray the costs of the acquisition.

### *(d) Continuing policy concerns*

Congress and the agencies charged with the enforcement of ERISA have increased activities to scrutinize plan terminations which result in the reversion of "surplus" assets to the plan's sponsor, but there is as yet no consensus that congressional action is required or appropriate. While the disadvantages of plan terminations for employees are relatively clear, it would be difficult to design legislative guidelines that preclude abusive terminations without impinging on a responsible employer's ability to terminate a plan for appropriate reasons, having the unintended detrimental effect on undermining plan funding, or causing employers to switch to defined contribution arrangements.

How a surplus is created, and how its size is determined, is the core issue in the debate over terminations designed to result in a reversion of assets to a plan sponsor. Surpluses can be inflated by using high interest rates to calculate mandatory cash-outs, or by using high interest rate assumptions to fund a successor plan in the case of a "spinoff" termination. Although the agencies which oversee the enforcement of ERISA are charged with review of such interest rate calculations, their ability to diligently protect the interests of plan participants may be limited by administrative workloads and divided enforcement authority. Absent a coherent and comprehensive joint policy developed among IRS, PBGC, the Treasury Department, and the Department of Labor, or legislation which mandates a joint policy, employees will be forced to bear the burden of the high cost of litigation to protect their pension rights.

### *(3) Multiemployer Plans*

The enactment of the Multiemployer Pension Plan Amendment Act of 1980 met with immediate opposition from employers contributing to multiemployer plans. Opposition continued to be voiced in 1983, particularly from employers owning small businesses, who have argued that since employers only contribute to the plans but do not set benefit levels, they should not be liable for the plan's unfunded benefit obligations. Under the act, liability is triggered by the employer's withdrawal rather than the termination of the plan itself, and some employers cite this provision as a significant obstacle to the sale or relocation of the business, or their ability to borrow money.

Although significant questions remain concerning the continued solvency of multiemployer plans under MPPAA and the act's effect on withdrawing employers, the most significant development of 1983 affecting such plans came in the courts rather than Congress. Since its enactment, over 100 lawsuits have been filed challenging MPPAA's retroactive effective date. Appellate courts reviewing MPPAA litigation have now split regarding the constitutionality of the effective date: The Seventh and Fourth Circuit Courts of Appeal sustained its constitutionality while the Ninth Circuit Court of Appeals ruled against it. The U.S. Supreme Court recently decided to examine the ninth circuit's decision, and will presumably take up its consideration in the upcoming year. Bills to eliminate the retroactive effective date, or make other amendments to MPPAA, have not been reintroduced in the 98th Congress, largely due to the lack of a consensus regarding the need for any particular change.

## (C) PENSION PLANS IN DECLINING INDUSTRIES

Employees working in industrial jobs face problems in assuring their retirement income security inherently different from employees in other sectors of the economy as a result of the nature of their employment. Long-term economic decline of large employers and industries in the United States promises a slow but steady flow of plant closings and plan terminations. This type of decline may be worsened by cyclical business trends, but due to foreign competition, displacement of labor by technology, and competition from newly formed nonunion competitors, it is not arrested by an improvement in the overall economy.

One symptom of a declining firm or industry is the ratio of retirees to active employees. As the employer's condition deteriorates, the ratio of retirees to active employees increases, resulting in a higher portion of the employer's labor costs being spent on retirement benefits than wages for active employment. A pension study of Fortune 500 firms indicates that average pension costs per employee rose from $1,405 in 1981 to $1,489 in 1982, a major factor in the increase being the drop in employment levels—as much as 15 percent—for the industrial companies included in the survey. But for selected industries, such as metal manufacturing and mining and crude oil production, more than 25 percent of the companies surveyed experienced an increase in pension cost per employee of 50 percent or more.[20]

In addition to affecting the employer's total costs, the funding of the pension plan itself can be undermined by a shift in the composition of the work force over time. In a typical pension plan, the majority of the pension costs of employing a particular worker are incurred during the last 10 or 15 years of employment. A growing firm will be hiring young employees continually for its work force. Their smaller pension accruals, as well as forfeitures if they terminate employment before vesting in a pension benefit, more than offset the larger costs represented by the older workers and plays a significant role in holding down the cost of funding the plan. But as an employer's condition declines, its work force generally becomes older. Layoffs in the order of seniority can accelerate this effect, until it reaches a point where the funding of the plan is adversely affected.

A number of major employers have recently attempted to counteract the financial consequences of an aging work force by implementing special early retirement incentives. These one-time "retirement windows" are designed to encourage employees within a certain age group to retire. They have been utilized in various industries, not merely to make room for promotions and new hires, but in the case of financially distressed employers, to prevent increased layoffs or plant closings.

The prospect of more workers exercising early retirement options at a time when the average age of the population is already increasing will present Congress with changing policy considerations. Historically, many workers have chosen to retire early even though choosing to do so would subject them to long-term financial penalties. To the extent that these workers' pensions are not adequately protected against inflation, for example, their buying power will be eroded over an even longer period of time than had they remained employed. The result would be an increased burden on the social security system to provide adequate retirement income and inflation protection.

---

[20] Johnson & Higgins, Executive Report on Large Corporate Pension Plans, 1983: Actuarial Costs and Liabilities, 1983, pp. 16–19.

Some distressed firms have turned to employer stock ownership plans (ESOP's) as a means of preventing layoffs or plant closings. By exchanging wages or retirement benefits for employer stock, employees have in some cases been able to preserve their employment. Likewise, the purchase of a faltering employer by its employees through the implementation of an ESOP has been credited with saving jobs both directly and indirectly. Such plans represent a calculated risk for employees, but depressed conditions in many industries and localities, especially in those communities whose inhabitants are principally employed by one industry or factory, are often sufficient to justify such risk in the minds of employees.

It is not clear, however, that ESOP buyouts are in the interest of all employees to the same degree. Older workers, less vulnerable to the long-term fortunes of the employer, may not wish to forfeit wages or other benefits in exchange for stock which may not accumulate fast enough to represent substantial benefits by retirement. The interest of older workers are determined to some extent by the adequacy of funding in existing defined benefit plans should the employer choose to cease business rather than sell the concern to employees.

The unfortunate result of these factors affecting declining employers is to induce some employers to compromise the interest of older employees in favor of those of younger employees—two groups with divergent needs, preferences, and employment options. Unless the United States experiences a revitalization of heavy industry, conflicting policy objectives will continue to confront Congress, challenging its Members to adequately meet the needs of both younger workers threatened with unemployment, and older workers seeking income security during the expected increased length of their retirement.

### (D) SIMPLIFICATION OF ERISA AND AGENCY ADMINISTRATION

Single agency bills have been introduced in each Congress since ERISA was enacted in 1974, and interest in single agency reorganization resurfaced again during the 98th Congress. A bill introduced by Representative Erlenborn (H.R. 3339), designed to create a single agency to oversee employee benefit plan administration, was introduced in June 1983. The bill would place responsibility for the administration of pension and benefit law in a newly created Employee Benefit Administration (EBA). Currently, regulatory responsibility is divided among the Treasury Department, Internal Revenue Service, Department of Labor, and the Pension Benefit Guaranty Corporation.

Representatives Erlenborn and Clay, cosponsors of the bill, have asserted that single agency administration is the key to the development of a national pension policy. Proponents of single agency proposals suggest that the present divided authority results in poor coordination between the agencies administering the act, and causes duplication, waste, confusion, inconsistency, and delays in the day-to-day administration of ERISA. Presently employers must seek approval from two or more agencies before certain actions can be taken, increasing the likelihood of delay and inconsistent agency responses due to competing policies or poor interagency communication.

Representative Erlenborn also introduced H.R. 3071, a bill intended to simplify ERISA, during 1983. The bill is actually a reintroduction of part of omnibus pension legislation introduced in the 97th Congress. The intent of H.R. 3071 is to eliminate unnecessary paperwork burdens and employee benefit plan costs, and to remove obstacles to the continued growth and creation of defined benefit plans. The bill includes amendments to ERISA definitions, reporting and disclosure requirements, fiduciary responsibility, funding, vesting, and participation requirements, and other miscellaneous corrections. Other sections of that omnibus bill, concerning single-employer insurance and single-agency administration, were reintroduced separately.

### (E) ENFORCEMENT OF FIDUCIARY PROVISIONS

When ERISA was enacted in 1974, it was in part an attempt to prevent the abusive misuses of plan assets by trustees prevalent in the pension industry. As the size of pension plan holdings increase, additional pressures are placed on plan trustees to use plan assets for purposes that are not in the best interest of employees and plan participants. Thus there is a constant need for the Department of Labor, the agency which enforces the fiduciary provisions of ERISA, to constantly review and refine its enforcement efforts. During 1983, attention was focused on two issues of fiduciary responsibility which can have a significant impact on the financial condition of a pension plan: The use of pension assets in corporate acquisition/control situations, and the investment of plan assets for "socially responsible" purposes.

### *(1) The Role of Pension Plans in Corporate Control Situations*

In many recent merger, acquisition, and corporate control situations, pension plans have been the largest shareholder of one of the corporations involved. Several recent court cases have addressed issues concerning the use of plan assets to determine the outcome of a corporate control situation. Use of pension funds in tender offers or corporate acquisitions must be closely monitored to insure that conflicts in interest are avoided and the best interests of plan participants are observed.

In *Martin Marietta Corp.* v. *The Bendix Corp.,* a Bendix stock savings plan held 23 percent of Bendix stock. The case turned on whether or not the plan trustee was prohibited under plan provisions from taking advantage of a lucrative tender offer by Martin Marietta. In such situations, plan participants can benefit if the plan tenders its shares at the premium price offered, but management officers often oppose such stock sales because a successful tender offer could cost them their jobs. The plan trustees, who take their directions from corporate management and may in fact be corporate officers of the plan sponsor, are thus placed in an intensive conflict-in-interest situation.

The *Grumman* case (*Donovan* v. *Bierworth*) examined the fiduciary standards applicable to the attempted use of plan assets as a defensive weapon in a takeover battle. The trustees of a Grumman defined benefit plan decided to reject a tender offer by LTV Corp., and proceeded to purchase additional Grumman shares at an inflated price to avert the takeover attempt. In the suit brought by the Department of Labor, the court ruled the trustees had acted imprudently by failing to act solely in the interest of plan participants.

Other cases have been litigated on related grounds, including a pending class action law suit challenging the use of a reversion of surplus assets to buy stock for an ESOP, allegedly to avoid any possibility of an unfriendly takeover. The Department of Labor has also filed suit *(Donovan* v. *Simmons)* in an attempt to prevent a plan fiduciary from allegedly using pension plan assets to acquire personal control of other corporations. Given the current frequency of mergers and acquisitions the role of pension assets in such situations will remain a high priority for fiduciary enforcement in the foreseeable future.

### *(2) "Socially Responsible" Investing*

As total pension plan funds approach $1 trillion, it is perhaps inevitable that specific, nontraditional uses for plan asset investments should be advocated. The significant growth in the size of pension trusts now makes it possible for plan asset managers to have an impact on markets and geographic economies by virtue of their investment activity.

"Socially responsible" investing can be defined as the knowing acceptance by a plan fiduciary of an inferior risk/return investment. If the analysis of traditional investment criteria must be completed before the social impact of a particular investment can be considered, then arguments over the "social sensitivity" of one investment as opposed to another—all other financial factors being equal—become irrelevant. At the core of the issue is whether a plan fiduciary can (or should) take factors other than those relating to investment performance into account when determining which investments will attract pension plan assets.

Social investments may include any number of applications of pension plan assets targeted for specific purposes. Advocates of such investing have placed increasing emphasis on projects which benefit plan participants directly, such as a construction industry multiemployer pension plan investing in home mortgages to stimulate construction and create union jobs. Likewise, pension plan trustees might wish to avoid investments in competing firms in other regions whose continued success and expansion could actually cost plan participants their jobs. The last decade has even seen efforts to organize investor boycotts of corporations which do business in South Africa, or which manufacture infant formula and market it in Third World countries.

Investing pension funds on the basis of social or political goals may create increasing costs or risks, and the acceptance of investments which will produce less than competitive returns may affect pension fund performance. The special nature of some "social investments" might impair the plan trustee's ability to fulfill fiduciary responsibilities to the plan, raising questions of diversification, conflict in interest, and overall prudence.

The debate over "socially responsible" investing raises two broad concerns for plan participants. The first question is simply who should bear the increased cost/risk of such investment—employee, employer, retiree? To some extent this issue depends on the plan's characteristics, whether it is a defined benefit or defined contribution arrangement, and what investment objectives were set for the plan. The second broad question raised is how to implement such decisionmaking? It cannot be assumed that retirees, older active workers, younger workers, highly compensated and lower paid employees all have the same social interests and objectives. Even if they do, how can it be guaranteed that these interests will be effectively communicated and implemented by the plan trustees?

The controversy that surrounds investment decisions which are sensitive to social or political objectives is reflected in the diversity of legislation introduced in Congress during 1983. Companion legislation introduced by Representatives Gephardt and Wyden, and Senator Packwood (H.R. 4243/S. 2096) is designed to ease pension law restrictions on fund investment in mortgages and mortgage-backed securities. Representative Erlenborn introduced his own residential mortgage bill in February (H.R. 1179). However, Senators Denton and Grassley have sponsored a bill (S. 2152) which would impose new penalties on social investing practices by private pension plans. Legislation was also introduced in September by Representative Corcoran (H.R. 3989) which would strengthen ERISA's fiduciary standards to assure adequate controls on alternative investment practices by pension plans. There is as yet no consensus that legislation is needed to change current agency enforcement policy.

### (F) FASB PRELIMINARY VIEWS

In 1974, the Financial Accounting Standards Board (FASB) initiated a comprehensive review of pension accounting principles in response to the enactment of ERISA. Now, almost 10 years later, the FASB has released "Preliminary Views" and a field test of its proposed changes in pension accounting. Present accounting standards governing disclosures of pension liabilities in corporate financial statements control the consistency of any accrual methods used, but permit corporations considerable flexibility in the choice of method. The FASB proposal is designed to accomplish two purposes: To bring consistency and uniformity to pension accounting in financial statements, and to move pension liabilities (or assets) from footnotes onto the balance sheet itself.

The FASB has received considerable criticism of its proposals from diverse elements within the financial community. Critics have complained that the proposals would impose an artificially uniform accounting method on corporate financial disclosures that is no more accurate than present methods and could increase the volatility of corporate finances without better serving the interests of investors and creditors. While some recognize the merits of placing pension liabilities on the balance sheet, many object that the employer's difficulty in measuring the required data outweighs those benefits.

Any proposals eventually implemented by the FASB may have an impact on future pension policy. Some pension experts have speculated that the transition from present practice to standards like those contained in "Preliminary Views" might discourage the growth of defined benefit pension plans based on final pay, and precipitate a shift toward defined contribution arrangements and career average plans which require ad hoc benefit adjustments to counteract the effects of inflation. If the proposals are adopted and have a substantial impact on corporate pension planning, design and asset mix, Congress may have to rethink current tax policy incentives to prevent a major decline in the use of certain types of defined benefit plans.

### (G) TAX POLICY AND EMPLOYEE BENEFITS

Interest in revising the tax treatment of pension benefits, and employee benefits generally, appeared in two forms during 1983. The first is a longstanding desire for simplification of the Tax Code which has appeared periodically, most recently as a modified flat tax proposal in the Bradley-Gephardt Fair Tax Act of 1983 (S. 1421). The second is an attempt to raise additional revenues by checking erosion of the tax base and reducing "tax expenditures" for employee benefits. Such efforts produced changes in the tax treatment of pensions in the passage of TEFRA in 1982, and a tax package (H.R. 4170) expected to be passed early in 1984 is likely also to include some provisions affecting employee benefits.

Such Tax Code reforms are partly a response to the growth of employee benefits as a percentage of total compensation. Employee benefits increased from an average of 5 percent of compensation in the 1950's, to 10 percent in 1970, and 15 percent by 1980. As of 1979, mandatory employee benefits (such as social security and unemployment insurance) and voluntary benefits (such as pensions and health insurance) make up roughly equal portions of average total compensation. During the last decade, employer stock ownership plans (ESOP's), group prepaid legal services, van pooling, educational assistance, so-called 401(k) (salary reduction deferred compensation) plans, and dependent care have all been added to the list of employee benefits receiving favorable tax treatment.

Recent changes in the Tax Code and the debate surrounding additional changes raise issues concerning the efficiency of the present mix of Tax Code incentives in meeting the policy objective of encouraging savings for retirement, retirement income security, and retirement planning. In February 1983, Senator Dole, chairman of the Senate Finance Committee, requested the Congressional Budget Office (CBO) to prepare an analysis of present tax incentives and private pensions. In his request, he asked several important questions. Who benefits most, and to what extent, from current tax incentives? How do these incentives vary by industry, income level, sex, and age bracket? How much are savings and retirement income actually increased by these tax incentives? How could incentives be restructured to encourage broader availability of retirement income for low-paid workers without jeopardizing the establishment and funding of plans? The request highlights the need for comprehensive, consistent, and authoritative estimates of "tax expenditures" on employee benefits, as well as the relative effectiveness of different tax incentives in furthering congressional policy objectives.

### *(1) Limits on Pension Benefits and Contributions*

Employer-provided pensions and profit-sharing arrangements, broadly characterized as deferred compensation plans, are tax deferred. Employers can deduct from their taxes contributions to the pension trust, and pension benefits are not taxable to the employee until actually received as income at retirement. Tax deferral is advantageous to an employee because the benefits are not taxed until the employee presumably is in a lower tax bracket, and to the employer because tax-free accrual of interest on pension fund assets permit them to make lower contributions to fund the plan over its extended life.

Pension benefits and contributions to pension trusts are limited under section 415 of the Internal Revenue Code. In 1982, TEFRA altered this benefit/contribution cap, lowering the maximum for a defined benefit plan from the prior indexed amount of $136,426 to $90,000, and by fixing the maximum for defined contribution plans at $30,000. The Fair Tax Act of 1983 (S. 1421) would reduce the maximum benefit allowable under a qualified defined benefit pension plan to $60,000, reduce the maximum annual contribution to a defined contribution plan to $20,000, and freeze both caps indefinitely. Critics of the proposal contend that further reduction in the section 415 limits, coupled with a failure to index such limits, would prevent employers from funding benefits for younger workers and would discourage the formation and maintenance of pension plans.

When faced with additional reductions in the section 415 limits, employers have three principal options: To use expanded nonqualified pension plans to maintain benefits for highly compensated employees at present levels, to shift compensation to nonpension benefits, or to increase wages in lieu of deferred compensation.

Although a shift to nonqualified plans would increase short-term revenues, the long-term practical consequences of such a shift may simply be to defer an employer's tax deduction for its pension expense. Even though the tax treatment of the benefit to the employee remains the same, at some income level the lack of PBGC termination insurance of benefits payable by a nonqualified plan will seriously impair the employee's retirement income security. Section 415 limits cannot be lowered beyond the point where these employees' benefit will be affected without undermining congressional policy encouraging the use of private pensions as a means of providing retirement income security.

Even though some defined benefit plans may have been constructed primarily to reward highly compensated employees, the nondiscrimination provisions of the Internal Revenue Code require employers to provide benefits to all other employees, which is to the advantage of lower paid employees. Once the benefit/contribution cap is pushed below a certain point, an employer may lose its incentive to maintain the advantageous benefit formula, or to maintain any defined benefit plan at all. Defined benefit plans play a major role in the retirement security of many employees because the employer bears the risk of providing promised benefits. To the extent that lower or nonindexed section 415 limits would precipitate a shift away from tax-qualified defined benefit plans with final pay benefit formulas, lower paid employees could experience a corresponding loss of retirement income and security.

Whether or not a tightening of section 415 limits would raise significant long-term revenues depends on how employer and employee respond to the change. If lower section 415 limits result in the replacement of present deferred compensation arrangements with an increase in taxable wages, tax revenues would increase. However, if employers choose to replace deferred compensation with tax-exempt fringe benefits instead, there would be a net loss of tax revenues, since pension benefits are tax deferred, not tax exempt. Before Congress further lowers the section 415 limits in an attempt to raise long-term revenues, it will have to carefully consider all of the dynamics of such a reduction.

### *(2) TEFRA "Top Heavy" Plan Restrictions*

Initial adverse responses to TEFRA as a whole have been mild. However, some opposition has been voiced to the administrative burden imposed by the necessity to conform with provisions applying to pension plans before TEFRA's effective date on January 1, 1984. Small employers in particular complained about "top heavy" plan requirements that were added to the bill in conference. Among the criticisms of the provision are problems with the definition of "key employees" affecting nonprofit organizations, and a claimed unfair impact on small employers because of the linkage of top heavy rules to the number of "key employees" in the firm rather than the size of the firm itself.

As the first session of the 98th Congress came to a close, however, attempts to repeal or delay the "top heavy"requirements had not made significant progress. Legislation introduced by Senator Bentsen (S. 1760) which would eliminate the 10-percent penalty for early distributions and change TEFRA's 6-year vesting schedule, as well as similar measures introduced in the House, have stalled. While the Treasury Department recognizes some problems with the top heavy provisions, and large employers have argued that they should not be required to comply with certain filing procedures because there is no possibility that their plans will ever become "top heavy," recommendations for changes, if forthcoming, are not expected until later in 1984.

### (H) PROGNOSIS FOR 1984

Ten years after the enactment of ERISA, 1984 may prove to be a pivotal year for the private pension system. As the 98th Congress approaches its close, opportunities remain to either amend ERISA in an effort to expand coverage and improve the adequacy of benefits for those who must rely most heavily on their pensions for retirement income, or simply continue the recent treatment of pensions on the basis of revenue policy. Congress has yet to establish a unified national retirement income policy. As ERISA begins its second decade, the task remains to expand private pensions to include, to the greatest extent possible, that portion of the work force which will otherwise be almost entirely dependent on social security after retirement.

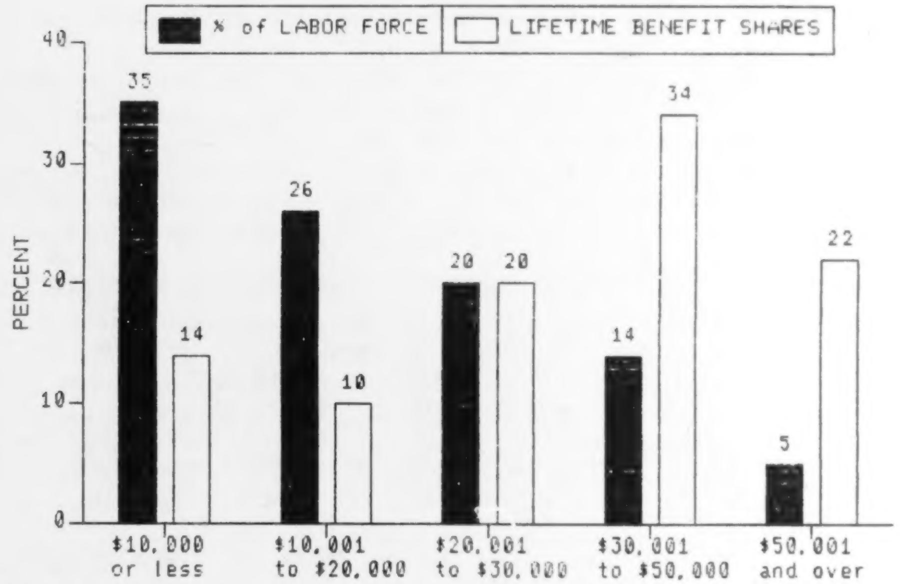
An analysis of lifetime pension-related tax benefits for workers under private pensions prepared by the Employee Benefit Research Institute offers some insights into the operation of current pension policy (see chart 5). The chart illustrates a simulation of the share of "tax expenditures" on private pensions that employees in particular income brackets are likely to receive over their entire lifetime. The analysis only applies to employees in a 25- to 34-year-old cohort because their entire work and retirement careers can be simulated.

A cursory examination of the chart might lead to the conclusion that present pension policy is generally fulfilling congressional intent. For example, persons in the middle-income groups ($20,000 to $50,000 annually) receive 57 percent of their age group's lifetime pension-related tax benefits. Thus middle-class employees, not the highly compensated, receive the majority of their age group's tax benefit shares.

But assuming that one of the objectives justifying Federal "tax expenditures" is to provide an additional layer of secure retirement income to those who would otherwise be unlikely to accumulate any savings for retirement to supplement their social security benefits, the conclusion to be drawn is less favorable. Although low-income workers (who are those least likely to have any significant savings for retirement) made up 61 percent of the cohort, they will only receive 24 percent of their age group's tax benefits. Workers with incomes of $30,000 or less made up fully 81 percent of the simulation's population, but will only receive 44 percent of lifetime pension-related tax benefit shares.

CHART 5

NET LIFETIME PENSION-RELATED TAX BENEFIT SHARES AMONG WORKERS AGE 25 TO 34 UNDER PRIVATE PENSIONS a/



a/ 1979 income in 1983 dollars
SOURCE: EBRI calculations based on PRISM simulation results and U.S. Dept. of Commerce, Bureau of the Census, Statistical Abstract of the United States, 1982-83, p. 257 (1983).

Some "tax expenditures" on pension benefits for high-income employees must be made in order to encourage employers to provide tax-qualified pension plans for all of their employees. The simulation model suggests that under current pension policy, Congress spends $3 on pension benefits for members of this cohort earning more than $20,000 for every $1 that it spends on workers earning less than $20,000. This difference is principally attributable to the fact that low-income workers tend to participate in and accrue vested benefits under a pension plan at a comparatively lower rate than high-income workers. If Congress wishes to direct a larger portion of pension-related "tax expenditures" to low-income employees, it will have to increase the rate of pension plan participation among this income group. Amendments to the Tax Code which cut pension-related tax benefits to middle- and upper-income employees to raise short-term revenues are not a substitute for comprehensive long-term changes in the mix of tax incentives for private pensions.

As our society has become more mobile, defined benefit plans have not been capable of meeting the demands of younger employees for increased portability of their benefits. Defined contribution plans have to some extent met that need, expanding coverage to employees who might otherwise never have vested in and received any deferred compensation from their employer. Unfortunately, many employees treat distributions from defined contribution plans more like severence pay than the retirement income it is intended to be, and frequently spend their distributions instead of reinvesting them.

Defined contribution arrangements often lower the employer's pension costs, and make its plan funding commitment more flexible, but they are also a less appropriate form of deferred compensation for particular employees. A guaranteed periodic defined benefit is of special significance to the retirement income security of less highly compensated workers, because the employer bears the risk of plan asset performance. Already strained by rising costs, regulatory burdens, and the specter of pension liabilities on the corporate balance sheet, defined benefit plans are subject to continuous challenges from new defined contribution alternatives recently created by Congress. The disproportionate impact that a deterioration in the long-term viability of defined benefit plans would have on lower earning employees must be a primary consideration for policymakers in the future.

At the end of 1983, several issues appeared to be of continuing importance. With the recent focus on women's issues and the "gender gap," the enactment of pension equity legislation is anticipated during the second session of the 98th Congress. Given the increasingly severe deficit facing the PBGC, single-employer termination insurance reforms also could be forthcoming, but it is not yet clear that an exceptable compromise can be worked out among all of the interested members of the pension community.

The remaining current issues affecting private pensions are much less likely to receive extensive consideration during 1984. Since it comes in a Presidential election year, the second session will be relatively short. Congress can be expected to concentrate on concluding old business rather than developing new substantive proposals or exploring new issues.

## B. STATE AND LOCAL PUBLIC EMPLOYEE PENSION PLANS

State and local pension plans were intentionally not covered under ERISA in 1974, yet many of them face financing difficulties due to the existence of large unfunded liabilities, and many offer less protection for participants' benefits than do private plans covered under ERISA. Most State and local officials, however, have opposed Federal regulation of their pension plans. The problems remain a focus of concern in the retirement income field.

### 1. Characteristics of State and Local Plans

The early development of State and local public employee plans predates the emergence of private pension plans. By the end of the 19th century, many large cities had pension plans covering groups of policemen, firemen, and teachers. Over 12 percent of the largest plans in current operation were in place before 1930. The number of public plans began to increase rapidly just before the enactment of social security and continued increasing until optional social security coverage was afforded State and local employees in 1950. Almost half of the largest State and local plans were established before 1950. Since then, the growth has been strongest for small public pension plans. Nearly two-thirds of the small plans have come into existence since 1950; a fourth of the small plans developed by 1975 were created in the 1970's.

In the last few decades there has also been a tendency for small plans to consolidate into larger plans. Over 40 percent of the larger State and local plans have increased their size by absorbing new employee groups. Over one-fifth of all plan absorptions completed by 1975 occurred in the first 5 years of the 1970's.

Currently, there are more than 6,600 State and local government pension plans with about 13 million active participants. These plans have assets of over $250 billion and pay out over $18 billion a year in benefits. They cover nearly all State and local government workers—but there remain 1 to 2 million public employees without pension coverage. Most of the plans are small plans, with over 80 percent of the plans having fewer than 100 active members. The largest plans, however, cover the bulk of the active participants. In 1975, there were 390 plans with 1,000 or more active members. While these large plans were only 6 percent of the total number of plans, they covered about 95 percent of the active membership of State and local government plans. Most covered employees (82 percent) participate in defined benefit plans exclusively. Another 16 percent participate in a combination defined-benefit/defined-contribution plan. More than four out of five participating employees were required to make employee contributions to their plans.[21]

Unlike Federal employees, State and local government employees are usually covered under social security in addition to their public pension plan. Since 1950, it has been possible for States to enter into voluntary agreements with the Secretary of Health and Human Services to provide social security coverage for their employees. As of 1975, over 70 percent of all State and local government employees were covered under social security. After coverage has been in effect for 5 years, State and local governments may also terminate social security coverage for a group of employees by giving notice 2 years in advance. Once coverage has been withdrawn, it can never be reinstated for that group. In recent years, several State and local governments have chosen to terminate coverage for groups of their employees. Between 1958 and 1979, States filed notices to terminate social security coverage for 1,112 State and local groups. Over half of those requests were filed between 1976 and 1979. Of the 1,112 requests, 700 terminations had become final by 1979 affecting about 130,000 employees, or 1 percent of the employees covered by social security.[22]

## 2. ISSUES

When the Employee Retirement Income Security Act (ERISA) was enacted in 1974, the Congress intentionally excluded Government retirement systems from the major provisions of the act to provide additional time for determining whether there was a need for Federal regulation of these plans. However, public pension plans were required to continue to comply with pre-ERISA requirements in the Internal Revenue Code which placed specific limitations on benefits and contributions, set participation standards to insure that such plans will not discriminate in favor of highly compensated employees, and required that funds be managed for the exclusive benefit of the plan participants and beneficiaries. (It should be noted that these code requirements are generally not enforced by IRS.) ERISA did include a requirement (section 3301) that several committees of the House and Senate establish a joint task force to study aspects of government pension plans—adequacy of levels of participation, vesting and financing arrangements, and existing fiduciary standards—and to report on the possible need for Federal legislation and standards. The pension task force report on public employee retirement systems, issued on March 15, 1978, by the House Education and Labor Committee, concluded that in a number of areas State and local public employee pension plans were deficient.

---

[21] U.S. Congress. House. Committee on Education and Labor. Pension Task Force Report on Public Employee Retirement Systems. Committee Print, 95th Cong., 2d Sess. Washington, U.S. Govt. Print. Off. 1978.

[22] U.S. Congress. Senate. Special Committee on Aging. State and Local Government Terminations of Social Security Coverage. Committee Print, 95th Cong., 2d Sess. Washington, U.S. Govt. Print. Off., 1978.

### (A) REGULATORY AND STATUTORY CONFUSION

The pension task force noted that there is variation and uncertainty in the regulatory and statutory provisions governing State and local pension plans, and in the interpretation and enforcement of these provisions. There is considerable confusion over how the Internal Revenue Code affects public employee pensions, particularly the sections relating to nondiscrimination and plan qualification requirements. The task force found that it was unclear how these provisions applied to public pensions. Theoretically, public pensions should be tax qualified to enjoy the same tax advantages as private plans, yet many public plans benefiting from these tax provisions are not.

### (B) PARTICIPATION, VESTING, AND PORTABILITY

The task force found that most public plans met ERISA's minimum participation and benefit accrual standards. However, fully 70 percent of the plans, covering one-fifth of the employees, did not meet ERISA's minimum vesting requirements.

Social security was found to be the best portability protection for public employees, and the only protection other than vesting of the pension for employees who changed from public to private sector jobs. However, most employees (82 percent) had some means for transporting pension credit to other government jobs within the same State, and 13 percent of the employees had a means for transporting pension credits to government employment outside the State.

### (C) REPORTING AND DISCLOSURE

One of the most serious problems identified by the pension task force was the lack of adequate reporting and disclosure of plan information to plan participants, public officials, and taxpayers.

The task force found that: Public employee retirement systems (PERS) at all levels of government are not operated in accordance with the generally accepted financial and accounting procedures applicable to private pension plans and other important financial enterprises. The potential for abuse is great due to the lack of independent and external reviews of the operations of many plans.

### (D) FUNDING

Another serious problem noted by the task force was the failure to adequately fund government pension plans to pay promised benefits. Plan participants, plan sponsors, and the general public were largely unaware of true plan costs. As a result, States and localities were failing to collect and make sufficient contributions.

The task force found that: The high degree of pension cost blindness which pervades the PERS is due to the lack of actuarial valuations, the use of unrealistic actuarial assumptions, and the general absence of actuarial standards.

While most plans had accumulated substantial funding reserves, the costs of pensions as a percentage of payroll were rising because of the lack of adequate funding practices. According to the task force, 75 percent of the plans using actuarial funding methods were understating the cost, and 40 percent of the total Federal, State, and local pension plans failed to meet the minimum funding test of pension experts. Almost 17 percent of the plans were funded on a pay-as-you-go basis—many of these in fiscally distressed cities or smaller cities and counties. These localities had no real assurances that their tax base in the future would be able to support the benefits promised.

### (E) BENEFIT REDUCTIONS AND LOSSES

The task force found that plan terminations and insolvencies were rare, but that when plans did become insolvent or terminated, participants could suffer temporary or even permanent benefit losses.

The evidence shows that public employees do face the risk of pension benefit reductions or other benefit curtailments due to reasons other than plan termination. For example, 8 percent of the pension plans at the Federal, State, and local levels covering 18 percent of the employees have been amended to reduce the value of past or future pension benefit accruals for active employees, while other plans have scaled back certain plan features for new employees only.

It appears that the greatest risk to public employees of having pension benefits reduced or other benefit features curtailed relates to governmental financial problems and the underfunding of public pension plans. Mismanagement, financing limitations, exceedingly high pension obligations, and financial emergencies have all contributed in the past to situations of pension plan insolvency or near-insolvency. As a result of these situations, some public employees have suffered temporary and, in a few cases, permanent benefit reductions.

### (F) INVESTMENT OF PENSION FUNDS

The task force found open opportunities for abuse in the management and investment of public plan assets. Some were found to have no statutory guidance at all, others operated under a tangle of conflicting statutes. There was a general absence of uniform standards of conduct.

The task force also found conflict of interest in many instances because of the investment of pension funds in State and local government securities. Restrictive investment practice were also found to have impaired investment returns to pension funds.

### 3. FEDERAL RETIREMENT PLANS REPORTING ACT

As an outgrowth of the pension task force report, Congress passed legislation extending the financial and actuarial reporting standards found under ERISA to Federal plans not covered by that act. The 39 plans covered by the Federal Retirement Reporting Act (Public Law 95-595) range in size from the civil service retirement system with 4.6 million participants and beneficiaries, to the plan for the Comptroller General with just 3 participants and beneficiaries. All plans in total cover 5.7 million active participants and 3.3 million former Federal employees and beneficiaries. The net plan assets available to pay benefits amounted to $75.5 billion for all Federal plans at the end of fiscal year 1980.

### 4. NATIONAL LEAGUE OF CITIES VERSUS USERY

The Supreme Court's decision in *National League of Cities* v. *Usery* (426 U.S. 833) (1976) is viewed by some analysts as a legal basis arguing against Federal regulation of State and local government pension plans. In the *National League of Cities* case, the Supreme Court held that extending the minimum wage and maximum hour provisions of the Fair Labor Standards Act to State and local government employees, based on the congressional power to regulate interstate commerce under the Commerce clause, was an unconstitutional interference with State sovereignty as reserved to the States under the 10th amendment. The Court recognized that regulation of wages and hours of State employees affects interstate commerce, but held that the congressional authority to regulate activities under the Commerce clause could not be used "to displace the States' freedom to structure integral operations in areas of traditional governmental functions."

The Court reasoned that determining State and local government employees' wages and hours was an attribute of State sovereignty and that these functions were essential to States' separate and independent existence. The latter point was based on an analysis of the effect the Federal legislation would have on State and local government functions. For several reasons (e.g., substantial increase in costs and displacement of State decisions in other areas), the Court felt that the legislation substantially interfered with traditional ways in which State and local governments carried out their internal affairs.

While an early public employee pension reform bill (the Public Service Employee Retirement Income Security Act of 1975, H.R. 9155) contained participation, vesting, and funding requirements, neither of the bills reported by the House Education and Labor Committee in 1982 contained these provisions.

The House Education and Labor Committee report on H.R. 4928 and H.R. 4929 states:

> The committee recognizes the importance of preserving and encouraging State and local regulation of public employee pension plans. The decisions of whether or not to establish a pension plan for State and local employees, who should be covered, what standards of eligibility should be met, what benefits are to be paid and whether, and to what extent, these benefits should be funded, are uniquely a part of State and local decisionmaking processes. These are therefore, not matters addressed by this bill.

### 5. Public Employees Pension Plan Reporting and Accountability Act of 1982 (PEPPRAA)

The proposed Public Employee Pension Plan Reporting and Accountability Act of 1982 (PEPPRAA, H.R. 4928), as favorably reported by the House Committee on Education and Labor, would have established reporting and disclosure requirements for State and local government pension plans including legal standards for managing and investing fund assets. Although the bill set up certain Federal requirements concerning reporting and disclosure, those requirements would not have applied to plans in States where the Governor certifies that State law contains substantially equivalent provisions. In addition, the reporting requirement generally would not have taken effect for about 5 years, thereby giving States the incentive to make any adjustments in their practices necessary to avoid Federal regulation. Specifically, the legislation would have:

—Required disclosure and reporting to participants and their beneficiaries, State and local taxpayers, employers, employee organizations, and the general public, of financial and other information about such plans.

—Established standards of conduct and responsibility for fiduciaries of public employee pension benefit plans.

—Extended favorable tax treatment to the benefits of participants and their beneficiaries in plans which meet the above reporting, disclosure, and fiduciary standards.

—Exempted plans which meet the above reporting, disclosure, and fiduciary standards from having to meet the present requirements under the Internal Revenue Code relating to plan benefits, contributions, and other section 401(a) conditions for plan qualification.

—Provided under section 501 of the Internal Revenue Code for all public employee pension benefits plans an unconditional exemption from the Federal income tax; and

—Provided for appropriate remedies, sanctions, and access to the Federal courts.

H.R. 4929, also favorably reported by the House Committee on Education and Labor, was identical to H.R. 4928, with the exception that it omitted changes to the Internal Revenue Code. Identical Senate bills (S. 2105 and S. 2106) were not reported from the Finance Committee.

## 6. RECENT DEVELOPMENTS

A report issued by the Census Bureau indicates significant changes in the composition and funding status of the State and local pension plans. According to the Census Bureau data, the number of retirement systems has consolidated from 3,075 in 1977, to 2,559 in 1982, largely as the result of efforts in Pennsylvania, Colorado, Oklahoma, and Wisconsin to bring municipal plans under State control. Since 1977, the ratio of active participants to retirees has declined from 4.5:1 to 3.5:1 in 1982.[23] Plan assets and contributions have increased substantially, roughly doubling during the 5-year period, but it is not yet clear whether the financial burden or more retirees in State and local systems is being adequately offset by improvements in plan funding. "Public Pension Funds, 1983 Report to Plan Participants," a study by Greenwich Research Associates of 325 pension funds with average yearly contributions of $70 million in 1981, found that even though total contributions were increasing, benefit payments were increasing at a faster rate and resulting in a net decline in plan contributions.

There is still no consensus that Federal, rather than State, regulation is needed to solve remaining problems concerning State and local plans. The extreme diversity in plan size, participant populations, and amounts of assets held by different plans make it difficult to identify systematic problems which might exist on a nationwide basis. Individual States have acted to avert financial crises by forming their own regulatory bodies to oversee plan investment and performance. Although opponents of Federal regulation cite the formation of such State commissions as obviating the need for Federal standards, the prior absence of any such standards may have contributed to the development of the crises themselves.

In one respect the obstacles facing some plans are more political than financial, however. State referenda that require a balanced budget have been passed or voted on in a number of States. Several State legislatures, attempting to deal with budget-balancing constraints, have turned to public retirement systems as a means of relieving budget deficit pressures. Because public plans are financed over an extended period of time, and yearly contributions are often quite large, they sometimes become targets for short-term budget cuts. Such actions are likely to remain controversial, as is evidenced by a recent California Court of Appeals ruling that the California Legislature violated the contractual rights of the participants in a State retirement system when it suspended contributions for 3 months. Yet continued taxpayer movements to cap expenditures could place even greater pressures on State legislatures to delay pension plan contributions—an action which, if continued for an extended period, could have a detrimental effect on the solvency of some plans given the trend toward increasing numbers of retirees compared to active employees.

Resolution of these issues is unlikely in the near future. In past years unions, retirees, and taxpayer groups have been the principal supporters of Federal public pension legislation, and reintroduction of such legislation can be expected before the expiration of the 98th Congress. State and local government organizations have consistently opposed such legislation, however. Opponents believe that a diversity of plan design and regulation is necessary to meet the divergent priorities and needs of different localities.

---

[23] Employee Benefit Research Institute. New Five-Year Census Shows Fewer But Better-Funded State and Local Pension Systems. December 1983.

## C. FEDERAL PENSIONS

### 1. FEDERAL CIVIL SERVICE RETIREMENT

Enactment of social security coverage for new Federal employees in the Social Security Amendments of 1983 touched off a period of significant change for the Federal civil service retirement system which should extend well into the next Congress. Social security coverage itself created both a need to restructure Federal pensions for new employees and an opportunity for the Congress to reexamine the overall structure of Federal employee compensation. Congressional committees charged with the task of designing a new pension plan initiated a lengthy study process, deferring the introduction of legislation until 1985. To meet the needs of employees hired in the interim, the Congress enacted a bill at the end of the session to provide temporary pension coverage.

Meanwhile, with mounting pressure on the Congress to close budget deficits, attention continued to focus in 1983 on the issue of rising entitlement spending. This kept the controversy going over whether the current retirement system is overly generous and too costly. An administration proposal, included in the fiscal year 1984 budget, sought to cut benefits and shift some of the Government's cost for the CSRS to employees. This proposal was quickly rejected by the Congress, which instead moved to simply delay the annual cost-of-living adjustment (COLA). At the end of the year, this proposal remained before the Senate as part of the budget reconciliation legislation to be considered in the second session.

#### (A) BACKGROUND

#### *(1) History* [24]

The civil service retirement system (CSRS) is an employee pension plan which was established in 1920 as a humane way to remove superannuated employees and to improve turnover in Federal civil service jobs. The original act established a pension in conjunction with mandatory retirement, at age 62, 65, or 70, depending on the job. In addition, pensions were provided to employees who became disabled after 15 years of service. The retirement annuity was based on final 10-year average salary and length of service. Financing for the pension came from an employee deduction of 2.5 percent of salary plus annual Federal appropriations as necessary to continue paying benefits. The first Government payments were made in 1928.

---

[24] U.S. Congress. House. Committee on Post Office and Civil Service. Background on the Civil Service Retirement System. Committee Print No. 98-5, 98th Cong., 1st Sess. Prepared by the Congressional Research Service, Library of Congress. Washington, U.S. Govt. Print. Off., 1983. pp. 1-3

In the 1940's, with growing awareness of income needs in old age, and the large-scale emergence of private pensions, the Federal Government as an employer began to place more emphasis on providing income security to its employees. During this period, mandatory retirement was relaxed, optional retirement and protection for survivors and discharged workers were added. At the same time, Federal civilian employment and coverage under CSRS expanded substantially, rising to a high in 1942 of over 3 million Federal workers. Improvements in protection necessitated increases in the employee contribution rate, which by the end of 1948 was raised to 6 percent of pay.

Through continued improvements in coverage and benefits, CSRS began to be viewed as a model of a modern employee benefit program. Most notably, in 1962, Congress enacted the first automatic cost-of-living adjustments (COLA's) for CSRS annuities to provide postretirement inflation protection. But growing demands on the CSRS led to financing inadequacies and to the enactment, in 1969, of Public Law 91-93. This law raised employee contributions to 7 percent of pay, made matching employer contributions mandatory, and created a system of automatic payments from the general fund to cover costs resulting from wage and benefit increases.

In recent years, rapidly rising CSRS outlays and growing Federal budget deficits, have prompted reductions in the CSRS. In 1976, the Congress began the process of eliminating aspects of the COLA mechanism which were causing the most substantial increases in benefits. Serious proposals continue to be voiced to further reduce annual increases in CSRS benefits.

### *(2) Provisions*

Today, the CSRS covers 2.7 million Federal civilian workers, and pays benefits to 1.4 million employee retirees and 0.5 million survivor annuitants. Benefits are paid to retired and disabled employees and to survivors of deceased employees. Full retirement benefits are paid to employees who retire after meeting age and service requirements (age 55 with 30 years service, 60 with 20 years, or 62 with 5 years). The average monthly benefit in fiscal year 1982 was $1,046 for retirees and $467 for survivors, an amount which is taxable once the annuitant has received an amount equal to the total of his employee contributions (now usually 14 months after benefits are first received). Under present law, benefits are adjusted for annual changes in the cost of living.

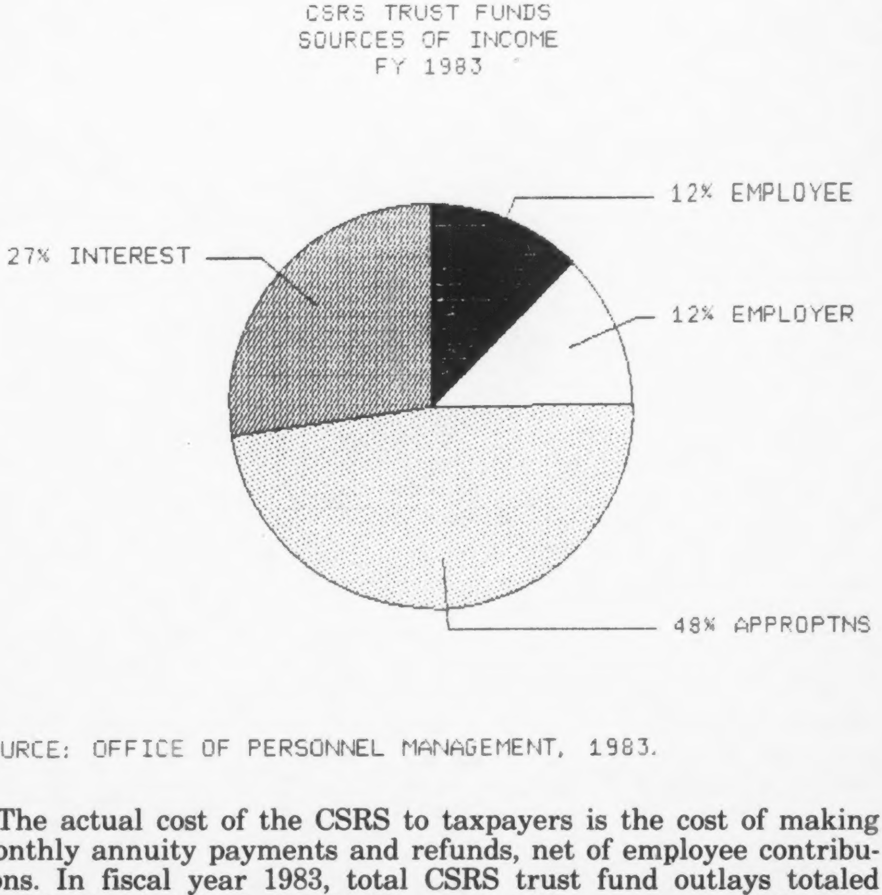
### *(3) Financing* [25]

CSRS is financed on a "pay-as-you-go" basis, with a trust fund account established to receive income and pay benefits. Income to the trust fund comes from matching employer and employee contributions of 7 percent of pay, from interest earned on the investment of trust fund reserves in Federal financial intruments and from additional general fund payments. These additional payments are required under Public Law 91-93 to pay interest on outstanding "unfunded liability," to amortize (over 30 years) the added cost of wage and benefit increases, and to pay for military service credit. In fiscal year 1983, income to the CSRS trust fund totaled $34.3 billion of which only $4.3 billion came from employee contributions. The remaining $30 billion in payments was transferred from Government accounts: $4.3 billion from employing agencies, $16.4 billion from the general fund for amortization, military credit, and interest on unfunded liabilities, and $9.3 billion from interest paid on trust fund assets.

---

[25] U.S. Congress. Senate. Committee on the Budget. Financing Work-Related Entitlement Programs. Committee Print. 98th Cong., 1st Sess. Prepared by the Congressional Research Service, Library of Congress. Washington, U.S. Govt. Print. Off., 1983. pp 301-313.

CHART 6



SOURCE: OFFICE OF PERSONNEL MANAGEMENT, 1983.

The actual cost of the CSRS to taxpayers is the cost of making monthly annuity payments and refunds, net of employee contributions. In fiscal year 1983, total CSRS trust fund outlays totaled $20.8 billion, of which $17.5 billion was paid to retirees and $2.8 billion to survivors; $16.5 billion of this amount was Federal Government payments net of employee contributions.

TABLE 1.—*CSRS trust fund income and outlays, fiscal year 1983*

| | *Billions* |
|---|---|
| Income: | |
| Employee contributions | $4.3 |
| Employer contributions | 4.3 |
| Interest on trust fund assets | 9.3 |
| Additional appropriations | 16.4 |
| Total | 34.3 |
| Outlays | 20.8 |
| Net budget effect | −16.5 |
| Balance of trust fund, Sept. 30, 1983 | 109.6 |

Source: Office of Personnel Management.

Amounts transferred to the CSRS trust fund which are not paid out as annuities and refunds accumulate as reserves. Reserves are used to purchase Treasury securities (i.e., they are loaned back to the Treasury). These reserves are actually a paper debt held by the CSRS trust fund which will be paid by taxpayers when they are redeemed in future years to pay benefits. They effectively convert a portion of future pension obligations to a paper debt. In fiscal year 1983, $13.5 billion was added to the reserves, raising total CSRS trust fund reserves to $109.6 billion, an amount sufficient to make 5 years of benefit payments.

The amount estimated to be needed to make future benefit payments not covered by CSRS trust fund assets is termed the "unfunded liability." Assuming continued wage and benefit increases, the "unfunded liability" of the CSRS is currently estimated to be $500 billion. Like the cost of redeeming the debt held by the CSRS trust fund, "unfunded liability" will actually be borne by taxpayers in the year in which benefits are paid. Together, the "unfunded liability" and the trust fund assets represent the total cost to taxpayers of making future benefit payments to current Federal employees. Projections by CSRS actuaries indicate that revenues from current financing mechanisms will be sufficient to make these benefit payments for the next 75 years.

### (B) ISSUES

#### *(1) Costs*

The cost to the Government of financing the CSRS has become a focus of criticism of the program. Whether or not the CSRS costs are excessive depends upon how they compare, on a per participant basis, to the costs other employers bear for similar plans, and how large a portion of the Government's resources are consumed in this activity.

Compared to the per participant cost of most private pension plans, civil service retirement costs seem high. The average large private pension plan, when combined with social security, has been estimated to cost the employer between 20 and 23 percent of payroll. Even though Federal employees contribute 7 percent of pay themselves to the CSRS, the Federal Government's payments amount to an additional 30 percent of payroll, nearly 50 percent more than the cost of the average private plan.[26]

Two features, in particular, of the CSRS contribute to making it a more expensive plan to operate than the average private pension plan: The full cost-of-living adjustment (COLA) for benefits after retirement, and retirement with full benefits as early as age 55. Private plans usually make cost-of-living adjustments on an ad hoc basis, limited to 3 or 4 percent a year. Only social security benefits are fully indexed. Additionally, full private pension and social security benefits are usually only available at age 65 and are reduced if taken at earlier ages. Probably half of the cost differential can be attributed to these features. A Congressional Research Service study completed in 1982 indicated that full COLA's and retirement at age 55 alone cost the CSRS 5 percent of payroll.[27]

Another aspect of concern about the cost of the CSRS is that annual outlays are large and growing, and that the Government's share of this cost is growing as well. Total payments from the CSRS trust fund have tripled, in current dollars, over the last decade, rising from $7.2 billion in 1975, to $20.8 billion in 1983, and an estimated $24.2 by 1985. At the same time, the proportion of this cost paid by the Government has increased from 65 percent in 1975, to 80 percent in 1983, and is estimated to exceed 80 percent by 1985.[28]

### *(2) Adequacy*

The public often assumes because the civil service retirement system costs relatively more to operate than a private retirement program that it provides better protection to Federal employees. However, in recent years, there has been increasing concern among experts that the CSRS provides inadequate protection for a portion of the Federal work force. Full career employees usually do well in the CSRS, but at the expense of more mobile employees. The civil service retirement system, like most employer-provided pension plans, tilts its compensation to reward long service and later termination, and provides proportionately high compensation to highly paid workers. Social security, by contrast, provides a basic retirement income to all employees, tilts its benefits to provide higher proportional compensation to lower paid workers, and does not penalize workers for job mobility or early termination.

Workers covered by social security plus an employer-provided retirement plan benefit from the contrasting advantages of each. However, Federal workers, covered only by the employer-provided plan, may receive inadequate benefits because they are not covered by social security. This inadequacy stems, in large part, from the lack of portability of Federal pension benefits. Employees must work 5 years to become vested in benefits and must work 10 years before the benefit formula begins crediting at full rates. Employees who leave after vesting may choose to withdraw their own contributions instead of qualifying for benefits, but if they do, they forego the value of the Government's share. If they leave their contributions in the system, they can receive retirement benefits, but the amount of the benefits will be fixed in relation to their salary at the time they left Federal service.

---

[26] U.S. Congressional Budget Office. Civil Service Retirement: Financing and Costs. Washington, U.S. Govt. Print. Off., 1981. p. 16.
Senate Budget Committee. Financing Work-Related Entitlement Programs. p. 311.

[27] Senate Budget Committee. Financing Work-related Entitlement Programs. p. 312.

[28] U.S. Office of Personnel Management. Unpublished Estimates, 1983.

These limitations result in Federal employees who spend less than a full career in Federal service frequently receiving little retirement income of value for their years of service with the Government. OPM estimates that 62 percent of all Federal employees coming in under the civil service retirement system will receive no Federal pension benefits. In all, two-thirds of the benefits paid will go to only one-fourth of the Federal employees. This would be less of a problem if those who left Federal service early received indexed or transferable credits for their years of service. But lack of social security coverage effectively denies them portable retirement benefits they would otherwise have received in the private sector.

### (C) DEVELOPMENTS

#### *(1) COLA's*

Because cost-of-living adjustments (COLA's) are the most expensive feature of the CSRS, they have become, in recent years, a prime target of cost-cutting efforts to reduce Federal budget deficits. In each of the last 4 years, the Congress has included changes in Federal civil service retirement COLA's in the annual budget reconciliation act. The most recent change, a delay in the payment of the COLA, was included in the Budget Reconciliation Act of 1983, which passed the House but was not taken up by the Senate in the first session.

Congress first authorized the automatic COLA in civil service annuities in 1962, a full decade before indexing was authorized for social security. The early method for indexing CSRS annuities provided for an annual increase equal to the percent increase in the CPI, triggered whenever that increase exceeded 3 percent. Over the following decade, provisions for indexing CSRS annuities were revised three times to improve the responsiveness of the annuity increase to inflation. Then in 1976, in exchange for the repeal of the 1969 provision which paid a COLA 1 percent higher than the CPI, the Congress converted the triggered COLA to a regular semiannual COLA, effective in March and October of each year.

Increasingly conscious of the effect of COLA's on the budget, the House and Senate Budget Committees began in 1979 to anticipate savings from changes in the COLA for Federal retirees. In the Budget Reconciliation Act of 1980 (Public Law 96-186), the Congress moved to a more conservative method of computing COLA's in the first year of retirement, replacing the "look-back" provision which paid retirees the higher of two options, with a simple proration of the COLA for initial annuities. In the Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35) the Congress shifted from semiannual to annual COLA's, making increases effective March 1 each year for the change in the CPI over the previous 12 month period ending December 31.

In 1982, as part of the Omnibus Budget Reconciliation Act of 1982 (Public Law 97–253), the Congress enacted, on a temporary basis, the first substantial reductions in the COLA for Federal civilian and military retirees. This act created two classes of Federal retirees for the purposes of paying COLA's: (1) Federal retirees 62 years of age and older, along with Federal disability and survivor annuitants, would continue to receive full COLA's; (2) Federal retirees under age 62 would receive for a period of 3 years (1983–85) partial COLA's which were guaranteed to be no lower than half the inflation rate specified in the law. The difference in treatment between younger and older retirees was based on the assumption that retirees under age 62 (the early retirement age for social security) can reasonably be expected to be working at another job and not yet fully retired. The 1982 act also delayed the COLA's of all annuitants by 1 month each year for 3 years. Under this law, COLA's of 3.9 percent for survivors, disabled, and age 62 and over retiree annuitants, and 3.3 percent for retirees under 62 were effective in April 1983.

In 1983, the Reagan administration included in the fiscal year 1984 budget a proposal to cancel the May 1984, COLA and extend beyond 1985 the payment of partial COLA's to Federal retirees under age 62. This COLA proposal was rejected by the Congress, along with a more controversial budget proposal to restructure the CSRS. Congressional critics found the cancellation excessive by comparison to the 6-month social security COLA delay then under consideration, and proposed instead a permanent 7-month delay in the payment of the CSRS COLA. On October 25, the House passed H.R. 4169, the Omnibus Budget Reconciliation Act of 1983, which includes a permanent shift of the COLA to December (beginning with the May 1984, COLA), and a corresponding shift in the CPI measurement period (to the period between the previous third quarter and the third quarter prior to that). H.R. 4169 was referred to the Senate, but was not taken up prior to the end of the first session.

With action to delay the May 1984, COLA still pending, the Reagan administration is planning to propose in the fiscal year 1985 budget, in addition to the delay, a reduction in COLA's on annuity amounts in excess of a specified limit. Similar proposals discussed in the past have suggested paying a lower COLA on annuities in excess of the social security taxable maximum ($37,800 in 1984). Proposals to pay a lower percentage COLA on higher annuities penalize full career Federal workers with moderate or high final pay, but do not affect the benefits of short-term workers with high final pay, many of whom may also receive substantial social security and private pension income.

### *(2) Civil Service Retirement Reform*

In recent years there has been an increasing interest in the Congress in reforming the civil service retirement system. Three major proposals have been introduced in the last 2 years, each of which would take a different approach to reforming the system. The first proposal, introduced at the end of 1982 by Senator Stevens, would have created an entirely new pension system for employees hired after the date of enactment involving social security coverage and a defined contribution pension plan. Senator Stevens' proposal would have left the existing system unchanged for current employees. The second proposal, introduced by the Reagan administration in the fiscal year 1984 budget, would have restructured the system for current employees to reduce benefits and increase the employees share of the costs. The third proposal, introduced in 1983 by Representative Erlenborn, would have modified the COLA provisions of the current system, and established a defined benefit plan for newly hired employees covered under social security. These three approaches provide a sense of the range of options being considered in the effort to restructure pensions for Federal employees.

### *(a) S. 2905—The Civil Service Reform Act of 1982*

On September 14, 1982, Senator Stevens introduced S. 2905—The Civil Service Reform Act of 1982—to provide a revised retirement plan for new Federal employees. The Stevens bill would have mandatorily covered all Federal and Postal employees hired after the date of enactment, and would have provided current employees the option to elect coverage in the new system. The new plan provided workers a three-tiered retirement system comparable to plans offered in private employment. The first tier of the new system was social security. New employees would have paid contributions to social security similar to those paid by current employees to the current civil service retirement system. These contributions were to be matched by the Government as employer. The second tier was to be a defined contribution plan. The Government would have contributed to an employee's account 9 percent of the first $20,000 (indexed) in pay and 16 percent for every dollar thereafter. There would have been no employee contributions to this plan. The third tier was to be a voluntary thrift plan The employee could have contributed any amount to this plan. The Government would have matched the employees' contribution up to 3 percent of salary. Employees would have vested in the new plan after 5 years of participation, allowing them to leave the Government with the entire amount in the retirement account. Alternatively, the employee could have left the account untouched after leaving Federal service, and it would have continued to draw interest until retirement. Initially, all employee accounts would have been invested within the budget in Government securities. Eventually, S. 2905 called for investing employee funds in the private market. S. 2905 would have also funded the entire unfunded liability of the current civil service retirement fund over a 40-year period.

The major advantages of the Stevens plan for Federal employees were the greater portability and the employer contributions made to individual employee accounts. These features would enable a person leaving Government service to take with them not only social security credits, but also a retirement account with preretirement inflation protection. In addition, this "up-front" contribution by the Government would have transformed, for a part of the total pension, the political risk inherent in the current CSRS ("will future obligations of the Government be met by Congresses of the future?") into a financial risk ("how rapidly will the retirement account grow compared to inflation?). This element of financial risk also appeared to be a disadvantage of the program for some. At the end of the 97th Congress, Senator Stevens annouced his intention not to pursue passage of his legislation until a majority of those affected by the proposal supported it.

### *(b) Fiscal year 1984 budget*

In recent years there has been growing concern that the civil service retirement system is expensive to operate and that it provides too generous benefits at too early a retirement age. In the 1984 budget, the Reagan administration proposed a radical restructuring of the CSRS to reduce both the longrun costs of the system and the Government's share of these costs. The net effect of the proposal would have been to raise the employee's cost from 7 to 11 percent of salary by raising contribution rates, and decrease the Government's cost from 30 to 11 percent by reducing annuities. Specifically, the administration proposed to:

(1) Increase the employee contribution rate from 7 to 9 percent in 1984 and to 11 percent in 1985.

(2) Raise the age at which full benefits are paid from 55 to 65 and reduce benefits by 5 percent for each year of retirement before age 65.

(3) Change the basis for computing annuities from the employee's highest 3 years of earnings to the employee's highest 5 years; and

(4) Reduce the percentage of the salary paid as a benefit (the replacement rate) by an unspecified amount.

The administration's proposals were met with immediate opposition in the Congress, and were never considered by the Senate Governmental Affairs Committee.

### *(c) Federal annuity and investment reform proposal*

On August 3, 1983, Representative John Erlenborn introduced a comprehensive legislative package "to provide the framework for a national debate on needed adjustments in the various Federal retirement-related entitlement and pension programs." His three-bill legislative package is known as the Federal Annuity and Investment Reform (FAIR) program.

The first bill (H.R. 3751) would place a cap on cost-of-living adjustments (COLA's) for retirees whose annual benefits exceed maximum benefits paid to certain new retirees under social security. For example, if the maximum social security benefit for 1984 is $10,000, retirees receiving annual combined federally sponsored retirement benefits above $10,000 would receive the full 100 percent COLA increase on only the first $10,000 of their benefits, and a maximum of 60 percent of the COLA on additional benefit dollars.

The second bill (H.R. 3752) would establish a defined benefit and thrift (savings) plan arrangement comparable to those found in the private sector to provide supplemental benefits for those Federal employees newly covered under social security. Under the defined benefit plan a worker would earn a benefit of 1.15 percent of final average salary for each year of service in addition to social security. For a worker with 30 years' service, this would amount to about 35 percent of the employee's highest 3 consecutive years' salary. For employees, retiring early, benefits would be reduced by

2 percent for each year under age 65 (e.g., a worker retiring at 62 would receive 94 percent of the benefit payable at age 65). Workers would be required not only to contribute 5.7 percent of salary to social security, but also to contribute 1.3 percent of salary to the defined benefit plan. (This would be the same as the 7-percent contribution current Federal workers make to the civil service retirement system.) In addition, employees could elect to contribute up to 3 percent of salary into a thrift plan. The thrift plan payment would be fully matched by an employer contribution.

The third bill (H.R. 3753) is designed to bring greater long-term stability to the financing of all Federal retirement plans, including social security, by providing a mechanism for limiting future annual postretirement benefit increases (COLA's) to the lesser of the increase in national wages or the increase in the Consumer Price Index (or other automatic mechanism currently applicable in the plan).

### *(3) Social Security Coverage*

The most momentous development of 1983 for the civil service retirement system was the enactment of social security coverage for new Federal employees, Members of Congress, and others in the executive and judicial branch. Social security coverage for Federal workers had long been proposed by pension experts as a way to improve their retirement income and, at the same time, improve the financial condition of the social security trust funds. Popular opposition was growing as well to the exclusion of Federal workers from a social insurance system that was compulsory for others.

Recommendations to extend social security coverage to Government employees began to emerge from advisory commissions almost immediately after the collection of the first social security tax. But the sentiment for extending coverage had became nearly universal in recent years. Since 1979, three study commissions on social security and pensions had recommended extending coverage to Federal employees, and a fourth—the Universal Coverage Study Commission—had reported to the Congress that coverage of Federal employees was feasible. By the time the National Commission on Social Security Reform convened in 1982, coverage of Federal employees had become so broadly supported that this panel was able to agree to it without debate.

The National Commission on Social Security Reform sent its recommendations for solving social security's financing problems to the President and the Congress on January 15, 1983. Included in the package was a recommendation to extend social security coverage to new Federal employees hired on or after January 1, 1984. The National Commission also alluded to the need to cover new employees with a supplemental employer-provided pension plan. On January 26, Commission members Senators Dole, Heinz, Moynihan, and others introduced the National Commission recommendations as S. 1. In this bill, coverage was additionally extended to all Members of Congress, the President, and the Vice President. The House, in H.R. 1900, further extended coverage to include executive branch political appointees, sitting Federal judges, and congressional employees not participating in the CSRS.

Strong opposition to coverage was voiced by Federal employee groups during February and March hearings on the National Commission recommendations before the House Ways and Means and Senate Finance Committees. Opponents expressed concern that coverage of new Federal employees would eventually bankrupt the CSRS trust fund for current employees and that the Congress would default on its pledge to develop a supplemental pension plan for new employees.

During consideration of the Social Security Amendments of 1983, efforts were made to respond to these concerns. Language in the House Ways and Means Committee report accompanying the bill expressed the commitment of committee members to the development of a supplemental pension plan, and language added in the Finance Committee stated that nothing in the legislation should be construed to affect existing rights under the CSRS. An amendment offered by Senator Long to delay coverage of new Federal employees until a supplemental pension plan could be enacted was approved by the Senate, but rejected in conference with the House because it would have extended the period for debate over coverage for several years. A preceding amendment offered by Senator Stevens to provide interim CSRS coverage to new Federal employees without an employee contribution was defeated in favor of the Long amendment.

Under the Social Security Amendments of 1983, signed into law by President Reagan as Public Law 98-21 on April 20, social security coverage was extended to the following groups of Federal employees, effective January 1, 1984:

(1) All Federal employees hired or rehired after a break in service exceeding 365 days on or after January 1, 1984; including executive, judicial, and legislative branch employees.

(2) Current legislative branch employees not participating in the CSRS on December 31, 1983; and

(3) All Members of Congress, the President, the Vice President, executive level political appointees, and Federal judges, including retired Federal judges resuming judicial duties.

Enactment of social security coverage brought about the immediate need to repeal the mandatory participation of new Federal employees in the civil service retirement system, and a long-term need to develop a supplemental pension for new employees. Because the Stevens amendment to eliminate the mandatory 7 percent CSRS employee contribution was defeated on the Senate floor, the Federal Government was to be required by statute to withhold 13.7 percent from the pay of employees hired in 1984—6.7 percent for social security and 7 percent for CSRS.

Just before the end of the first session, the Congress agreed to an interim civil service retirement plan for new employees to resolve the double withholding problem. Drafting of an interim plan had been deferred because of disagreement between Federal employee groups and the administration. Federal employee groups insisted that an interim plan keep new employees in the CSRS and that the Government continue full funding of the CSRS during this period. The administration opposed covering new employees under the existing CSRS and proposed instead that new employees be covered under a separate agreement. By November, the Senate Subcommittee on Civil Service, Post Office, and General Services was finally able to report out a temporary civil service retirement plan, which was approved by the Senate on November 4 as an amendment to H.R. 2700, the Federal Physicians Pay Comparability Allowance Amendments of 1983. The conference report on H.R. 2700 was approved by both Houses on November 12 and signed by the President on November 29 as Public Law 98-168.

The interim plan is designed to provide supplemental coverage for new employees under the CSRS while maintaining an equitable rate of withholding between new and current workers. In addition, the interim plan assures that the necessary Government contributions will be made to maintain the CSRS trust fund. The plan provides temporary coverage until December 31, 1985, at which time double withholding will resume unless a supplemental plan has been enacted in the interim. Federal employees hired on or after January 1, 1984, will have 1.3 percent of pay withheld for the CSRS, in addition to the 7 percent withheld for social security including medicare. Total withholding of 8.3 percent for new employees will equal the withholding of 7 percent for CSRS and 1.3 percent for medicare for current workers. New Federal employees will be eligible for death or disability under the plan once they have met CSRS vesting requirements, but will have any benefits received on the basis of this interim coverage reduced by the amount of any social security benefits creditable to this period. Employees will not be eligible for retirement benefits during this period unless they make a deposit for the difference between the 1.3 and a full 7 percent contribution, but they will receive retirement credit for service during these years under the future supplemental plan.

#### (D) PROGNOSIS

The design of a supplemental pension system for new Federal employees now covered under social security will continue for the remainder of 1984. Sometime in 1985, the Congress will begin drafting legislation to implement the new plan, in order to have the new plan in place before the interim provisions expire. Proposals to modify the system for current employees or reduce annual COLA's, other than those now contained in pending legislation, are not likely to receive serious consideration by the Congress in the near future.

### 2. MILITARY RETIREMENT

#### (A) OVERVIEW

In fiscal year 1983, an estimated 1.3 million retired officers and enlisted personnel and their beneficiaries received $16.4 billion in annuity payments. On December 12, 1983, the Department of Defense (DoD) Appropriation Act (Public Law 98-212) earmarked $16.6 billion for this same fund, bringing expenditures for military retirement to between 7.5 and 8 percent of total defense expenditures in fiscal year 1984.

With the exception of a minor cost-cutting measure to round benefit checks to the next lower full dollar, administration proposals to save an estimated $282 million were unsuccessful in the first session of the 98th Congress. (An additional proposal to delay the fiscal year 1984 cost-of-living adjustment (COLA) currently scheduled for May 1, 1984, until December 1984, is still pending as part of the budget reconciliation package.)

The military retirement system has been the target of repeated study and discussion owing to its rapidly escalating costs and its benefit provisions which some critics feel are too generous. Outlays have mushroomed from fiscal year 1960, when total costs were $693 million (about 2 percent of the total Defense Department budget) to the current $16.4 billion figure, to an estimated cost in 2000 of nearly $45 billion. Since 1969 no fewer than 9 separate studies have put forth recommendations which would reduce the cost of the system. However, no comprehensive legislation has yet been passed.

Critics argue that the system provides benefits which are too generous given the recent emphasis on budget cost containment, especially when compared with other public and private retirement plans. In its report issued in July 1983, the President's Private Sector Survey on Cost Control (PPSSCC) concluded that benefits provided by the military retirement system were six times more costly than those provided by the best private sector plans. Critics also contend that allowing members to retire after 20 years at 50 percent of active duty basic pay, in addition to being too expensive, no longer serves an effective manpower management purpose. It prolongs careers of certain personnel beyond their usefulness by not providing them any retirement option prior to 20 years. On the other hand, it encourages experienced and highly trained personnel in their forties to leave the forces for public and private sector jobs at higher salaries immediately upon qualifying for retirement pay. Fully 87 percent of military retirees are under age 65.

Supporters of the current military retirement system point to a number of variables unique to military life which they feel justify the benefits provided. First, they point out, all retired members are subject to involuntary recall in case of a national emergency. Hence, military "retirement" pay is compensation for this exigency. Moreover, military service puts special demands on the employee which are not present in other public or private employment, the so-called "*x* factor." Finally, it is argued that the hardships of military service are better borne by younger men and women and that the military requires "youth and vigor" of its members to cope with these special dangers and stresses, both present and potential. The 20-year retirement provision provides a strong incentive for "older" members to retire once they are entitled to military retirement pay.

Despite the debate, the military retirement system has remained, as one journalist put it, "high on the list of politically untouchable programs."[29] This is likely to remain true throughout the second session of the 98th Congress, despite the pending report of the Fifth Quadrennial Review of Military Compensation (5th QRMC) which, preliminary reports indicate, will recommend revisions of the 20-year retirement system.

---

[29] Loeb, Vernon. The Lasting Pension of the Military. The Philadelphia Inquirer, July 18, 1983.

## (B) BACKGROUND

### *(1) History*

#### *(a) Officers retirement pay*

In its earliest days, military service provided few if any benefits upon the members' retirement. Prior to 1861 (and with the exception of certain Naval officers), there was no provision for voluntary or involuntary retirement of active duty members. Mandatory retirement at age 64 was not introduced until 1882. The result of this policy (or nonpolicy) was twofold: promotion stagnation, and a military leadership unable to command owing to infirmity or disability. Junior officers often exercised field command beyond their ranks. As the 19th century progressed, Congress, reacting more to the exigencies of successive wars than to any comprehensive personnel management policy, enacted a series of separate retirement provisions for each branch of the military. These took into consideration years of service, physical disability, and age, as well as the need for a promotion flow within the officer corps.

The act of August 29, 1916 (Public Law 64-241) established two principles of current nondisability retirement in a revision of the Navy retirement system: The up-or-out selection promotion plan; and the formula of the 2.5 percent of monthly active duty basic pay for each year of service to determine retirement benefits. The Army and Air Force Vitalization and Retirement Equalization Act of 1948 (Public Law 80-810) standardized voluntary retirement authority for officers across all branches of the service. It required 20 years of service, at least 10 of which were comprised of commissioned service. It was not until the Defense Officer Personnel Management Act of 1980 (Public Act 96-513) that Congress unified the involuntary retirement standards by grade across all branches according to pay grade and years of service.

#### *(b) Enlisted personnel*

The legislative history of nondisability retired pay for enlisted personnel is far less complex than that for officers. There has never been a provision regarding involuntary retirement for enlisted personnel. In order to weed out the ranks, certain personnel were turned down for reenlistment. Voluntary retirement after 30 years (at the discretion of the Secretary concerned), was standard in all branches of the Armed Forces by 1907, and retired pay uniformly set at 75 percent of active duty basic pay plus allowances for quarters, fuel, and light.

With the Career Compensation Act of 1949 (Public Law 81-351), the 20-year voluntary retirement provision was established for both enlisted and officer personnel. Regardless, all retired military personnel are subject to recall at any time.

### *(2) Major Elements*

#### *(a) Nondisability retired pay*

Nondisability retired pay is by far the largest (and hence the most often debated) component of the military retirement system. Nearly 1.2 million retirees, or 89 percent of the total number of those receiving annuities in fiscal year 1983, received nondisability pay. Expenditures in fiscal year 1983 amounted to about $14.5 billion.

Any member voluntarily retiring from active duty after 20 years of service, or who is retired as a result of law or policy (for reasons other than physical disability), is entitled to nondisability retired pay immediately upon retirement. Retired pay is based on a formula of 2.5 percent of a member's active duty basic pay (i.e., exclusive of allowances and special pays which, along with basic pay, comprise the member's active duty compensation), for each year of service. The minimum retired pay is 50 percent of the member's basic pay (for 20 years of active duty service). The maximum is set statutorily at 75 percent of basic pay (or 30 years of active duty).

The basic pay figure used varies according to when the member retired. For those who enlisted before 1980, terminal basic pay is used. Those who enlisted after 1980 will receive retired pay based on the average of their highest 36 months. In addition, in calculating years of service, three different standards are used to determine years of service depending on when the member was entitled to retire. Under a provision in the Defense Authorization Act in 1983 (Public Law 98-94), all completed months of service are now included in the calculation.

One of the most significant aspects of military retired pay is its protection against inflation. Since the passage of the Uniformed Service Pay Act (Public Law 88-132) in 1963, COLA's, based on a percentage increase in the Consumer Price Index (CPI) have been periodically provided to military retirees, although the price formula has been modified many times. In 1982, the Omnibus Reconciliation Act (Public Law 97-253) temporarily changed permanent law on COLA's in two ways. First, it imposed partial COLA's for all nondisabled retirees under the age of 62. Second, it created a 3-year temporary deviation delaying COLA's for all Federal retirees until April, May, and June in fiscal years 1983, 1984, and 1985 respectively, providing a 13-month, rather than a 12-month interval between them. While the next COLA is scheduled for May 1, 1984, under current law, a provision now pending in H.R. 4169 would further delay the 1984 COLA until January 1985.

### *(b) Disability retirement benefits*

Members found unfit for duty because of physical disability may be retired on disability retired pay provided that: (1) The disability is not the result of intentional misconduct or willful negligence, and did not occur during an unauthorized leave of absence; and (2) the member is more than 30 percent disabled (as judged by standards established by the Veterans Administration (VA)), or has 20 years of service. Persons with less tha 20 years of service and less than 30 percent disability are separated with separation pay, though some members with less than 20 years of service are eligible to receive compensation from the VA.

Disability retired pay may be computed one of two ways, depending upon which formula provides the largest benefit to the retiring service member. The first is the standard 2.5 percent of basic pay for each year of service. The second is percentage of disability multiplied by active duty basic pay. In either case, the 75 percent maximum benefit rule applies. For 5 years prior to being assessed as permanently disabled, members are put on a temporary disability retired list (TDRL), and are subject to periodic examinations to determine whether they should be returned to active service or retired.

In fiscal year 1983, disability retired pay cost $1.4 billion, and amounted to 8.5 percent of the total cost of the military retirement system. An additional $9.8 billion was paid to veterans with service-connected disabilities under VA compensation. Members are occasionally entitled to benefits from both military retirement and the VA compensation. In such cases, military retirement pay is offset dollar for dollar by the amount received from the VA. Since VA compensation benefits are tax free this often benefits the disabled retiree.

### *(c) The survivor benefit plan*

The third and smallest component of the military retirement system is the survivor benefit plan (SBP). In fiscal year 1983, payments amounting to $454 million, or 2.8 percent of total military retirement outlays, were made.

Since it was enacted in 1972 (Public Law 92-425), the SBP has provided annuities to surviving spouses, former spouses, dependent children, or any person with an insurable interest in the service member. The program follows an earlier survivor protection plan (the uniformed services contingency option plan, enacted in 1953 by Public Law 83-239, revised in 1961 to the retired serviceman's family protection plan by Public Law 87-381) which provided lesser benefits to recipients, and which suffered from poor participation rates. In main, this was due to the high cost for participation since survivor benefits were funded entirely from a reduction in the member's retired pay. The costs of providing the annuity under the SBP are shared by the Federal Government and retired members. About 70 percent of costs are offset by a reduction in retired pay elected by the retiring member according to the coverage chosen. The minimum annuity provided under the plan is $300 a month, the maximum is set at 55 percent of the member's retired pay.

Like disability and nondisability retired pay, SBP does receive CPI increases and is offset for any VA benefits received. However, unlike the other two elements of military retirement, SBP is partially integrated with social security benefits.

## (C) LEGISLATIVE ACTION—1983

### *(1) Fiscal Year 1984 Funding*

Administration proposals in 1983 focused on curbing costs through changes in the COLA provisions of the military retirement system, for a projected savings of $282 million. The average cost to retirees of these proposals was estimated at $34 each month. However, of three cost-reduction proposals made by the administration, only one was actually enacted in 1983 for a projected savings of $9 million each year through 1987. Another is still pending before the Congress.

The first proposal would delay the fiscal year 1984 COLA scheduled for May 1 until December 1984. The language which is contained in the budget reconciliation package would permanently make all subsequent Federal retiree COLA's effective in the month of December. Congress adjourned on November 18 without completing action on the budget reconciliation, leaving the 1984 COLA scheduled for May 1 until Congress takes final action.

The second administration proposal would have instituted a permanent half-COLA for nondisabled retirees under the age of 62 for all Federal retirees, including military retirees. This was supported by the rationale that: (1) It would bring inflation protection for Federal retirees more into line with that afforded non-Federal retirees; and (2) nondisabled retirees under 62 years of age are more likely to have income from part- or full-time employment. A House-passed version of the Defense Authorization Act would have extended this provision until fiscal year 1986. However, the Senate Armed Services Committee objected that the burden of the half-COLA provision would fall disproportionately on military retirees. Four of five military retirees, but only one of five civil service retirees is under age 62. The Senate prevailed in the conference committee.

Only the administration's third proposal, to round monthly retired pay checks to the next lower dollar, was included in the Defense Authorization Act and ultimately passed into law. The provision, which became effective October 1, 1983, has a projected savings of $9 million each year through 1987. The Department of Defense estimates that retirees will lose between $0.12 and $11.88 each year due to the provision.

### *(2) Administrative Changes*

The administration was relatively more successful with several administrative changes in the military retirement system.

#### *(a) Accrual accounting*

Language authorizing accrual accounting for the military retirement system was included in the fiscal year 1983 Defense Authorization Act (Public Law 98–94). The DoD military retirement fund, to be administered by the Secretary of the Treasury, will become operational October 1, 1984. Funds will be accumulated in this fund in order to finance the military retirement system.

Under prior law the military retirement system was funded through general operating funds. The amount allocated on a yearly basis reflected the cost of providing annuities to current retired personnel. Under the accrual accounting system, allocations in the DoD budget will reflect the present cost of providing future retirement benefits to current active duty personnel and will put the military retirement system into the same fund with the civil service retirement system, one large Federal retirement account.

TABLE 2.—BUDGET CHANGES UNDER MILITARY RETIREMENT ACCRUAL

[In billions]

| Budget function | Fiscal year— | | |
|---|---|---|---|
| | 1985 | 1986 | 1987 |
| 051—Defense: Accrual amount (50.7 percent of basic pay) | $16.2 | $17.3 | $18.5 |
| 600—Income security: Appropriation to liquidate unfunded liability[1] | 17.4 | 18.5 | 19.3 |
| Total | 33.6 | 35.8 | 37.8 |
| Less payment to retirees | 17.4 | 18.5 | 19.3 |
| Net change, Federal budget[2] | +16.2 | +17.3 | +18.5 |
| Net change, Defense budget[3] | −1.2 | −1.2 | −.8 |

[1] Amount assumes unfunded liability will be appropriated each year to cover acutal payments needed for all former military on retirement rolls as of Oct. 1, 1984. Board of Actuaries will determine how quickly unfunded liability will be funded.

[2] The increase in budget authority does not represent additional cost to the Government, but rather provides for the recognition that a liability exists and would continue to grow without enactment of the proposed legislation.

[3] This represents the difference between carrying the accrual amount in the Defense budget and including payouts under the income security function of the Federal budget.

Though it results in a net change in both the Defense and general Federal budget (minus $1.2 billion in the former, plus $16.2 billion in the latter in fiscal year 1985), there is no overall change in the obligation on the part of the taxpayers. The increase in Federal budget authority does not represent an additional cost to the Government, but rather recognizes that a future liability of retirement payments to current active duty personnel exists. The decrease in the Defense budget represents the difference between the cost of paying benefits directly and the cost of making contributions to the trust fund (estimated at 50.7 percent of basic pay for each member). Spending under the income security function of the Federal budget will increase by the cost of the payouts to retired military personnel. The change does not affect the amount of retirement benefits paid to the member.

Potentially, it will provide a more accurate picture to manpower planners of personnel costs on an ongoing basis. The danger of employing such an accounting system is the sensitivity of cost projections to assumptions about future prices, wages, interests, and personnel retention rates. Error or manipulation could result in unwarranted increases or decreases in allocations for the retirement fund within the Defense budget. Congress has sought to mitigate this risk by providing a neutral panel of three actuaries from outside the DoD.

### *(b) Repeal of 1-year "look back"*

The act also contains a provision repealing the 1-year "look-back" provisions enacted in 1967. That provision allowed personnel to elect to receive retirement benefits based on the pay scale employed in the year immediately preceding their retirement, in addition to any retired pay COLA's made during that year. Retired pay COLA's often exceeded CPI increases in active duty pay for the same year, and thus with the "look-back" provision retirees received larger retirement benefits than they would have based on their actual final pay.

An August 1982, General Accounting Office report stated that the 1-year look back should be repealed because it was no longer justified. The administration had recommended that Congress repeal the provision in its fiscal year 1983 budget request, and did so again this year. No savings are anticipated from this legislation unless retired pay COLA's outstrip increases in active duty pay (as has happened in the past). In any event, the provision is not effective until September 1985, and contains a "save-pay" clause insuring that members who retire after 1985 will not receive lower benefits than they would had they retired before the provision was eliminated.

### *(c) Six-month rounding*

The Defense Authorization Act also repealed the rule which required that service of less than 6 months within service year be disregarded for the purposes of computing retired pay. For members retiring after September 30, 1983, each completed month of service will be counted for such determinations.

### *(d) Reservist retired pay and SBP benefits*

The act also authorizes retired pay for reservists who served on active duty during the Berlin crisis, Cuban missile crisis, or Vietnam War, but did not serve on active duty during one or both World Wars, although they served in the Reserves during those wars. Formerly, all reservists who had served during the World War I or World War II period, but did not serve on active duty during either World War or the Korean conflict were ineligible for Reserve retirement pay at age 60.

In addition, the fiscal year 1984 Defense Authorization Act insured benefits under the SBP to two classes of spouses: Former spouses who were not entitled to SBP benefits prior to the Former Spouse's Protection Act (Public Law 97-252); and, destitute spouses who would have been covered by the SBP, but whose husbands died just prior to enactment of the legislation. In the case of the former, this year's legislation allows only spouses who had already made a SBP election at retirement, to redesignate their former spouses as annuitants, if the member chooses. In the case of destitute spouses of members who died prior to the enactment of SBP, the provision corrects an oversight in the original legislation which provided an additional 6-month enrollment period for eligible spouses, but did not amend the supplemental income provision to cover that additional period.

## (D) ISSUES

The military retirement system has been highlighted by numerous commissions and the media, along with the civil service retirement system (CSRS), as one of the principal programs aggravating the Federal budget deficit. In the case of military retirement, the problem of escalating costs is compounded by the specter of persons in their forties retiring at 50 percent of basic pay, a full 15 to 20 years before their civilian counterparts are able to retire. A principal criticism of military retirement is that it simply does not take into account that retirement at early ages means retirement to another job.

The temptation to draw comparisons based solely on economics is difficult to avoid, especially absent any immediate threat of war.

On the one hand, critics maintain that since military pay has been brought into line with civilian wages for comparable jobs, the impetus no longer exists for continuing to compensate retired military at rates of between 50 and 75 percent of pay. On the other hand, proponents of the current system maintain that military service is qualitatively different than civilian employment, so the more liberalized provisions of the military retirement system are necessary compensation. Many point out that, while benefits paid to officers may seem large, benefits to enlisted personnel are far smaller. Proponents maintain that retired pay is not overly generous as it is not enough to sustain the member and his family in the member's "retirement." In addition, they argue, the likelihood of the member finding a comparable job upon leaving the service is slim.

## TABLE 3.—NUMBER OF MILITARY PERSONNEL RETIRED DURING FISCAL YEAR 1982 AND RECEIVING RETIRED PAY, AS OF SEPTEMBER 1982, BY RANK

| Rank/grouping | All retirees excluding reserves |  |  | Nondisability excluding reserves |  |  | Disability only |  |  |
|---|---|---|---|---|---|---|---|---|---|
|  | Number | Monthly |  | Number | Monthly |  | Number | Monthly |  |
|  |  | Average net | Average gross |  | Average net | Average gross |  | Average net | Average gross |
| 0–10 | 5 | 4,396 | 4,924 | 5 | 4,396 | 4,924 | 0 | 0 | 0 |
| 0–9 | 11 | 3,956 | 4,439 | 11 | 3,956 | 4,439 | 0 | 0 | 0 |
| 0–8 | 72 | 3,622 | 3,872 | 71 | 3,525 | 3,874 | 1 | 3,374 | 3,721 |
| 0–7 | 38 | 3,034 | 3,346 | 36 | 3,028 | 3,344 | 2 | 3,148 | 3,390 |
| 0–6 | 1,802 | 2,472 | 2,651 | 1,752 | 2,479 | 2,649 | 50 | 2,216 | 2,717 |
| 0–5 | 2,963 | 1,723 | 1,818 | 2,898 | 1,725 | 1,813 | 65 | 1,641 | 2,044 |
| 0–4 | 1,949 | 1,365 | 1,421 | 1,886 | 1,366 | 1,416 | 63 | 1,360 | 1,583 |
| 0–3 | 598 | 1,180 | 1,247 | 507 | 1,221 | 1,258 | 91 | 953 | 1,183 |
| 0–2 | 38 | 859 | 946 | 12 | 989 | 1,019 | 26 | 800 | 913 |
| 0–1 | 11 | 639 | 703 | 0 | 0 | 0 | 11 | 639 | 703 |
| All commissioned | 7,487 | 1,790 | 1,897 | 7,178 | 1,807 | 1,906 | 309 | 1,381 | 1,676 |
| W–4 | 448 | 1,458 | 1,549 | 428 | 1,468 | 1,552 | 20 | 1,231 | 1,493 |
| W–3 | 371 | 1,031 | 1,089 | 350 | 1,034 | 1,079 | 21 | 581 | 1,242 |
| W–2 | 262 | 858 | 907 | 247 | 863 | 907 | 15 | 767 | 901 |
| W–1 | 7 | 581 | 706 | 2 | 864 | 864 | 5 | 468 | 642 |
| All warrant | 1,088 | 1,162 | 1,232 | 1,027 | 1,174 | 1,234 | 61 | 968 | 1,191 |
| All officers | 8,575 | 1,710 | 1,813 | 8,205 | 1,728 | 1,822 | 370 | 1,313 | 1,596 |
| E–9 | 2,436 | 1,306 | 1,375 | 2,372 | 1,311 | 1,374 | 64 | 1,130 | 1,388 |
| E–8 | 5,321 | 951 | 996 | 5,159 | 954 | 994 | 162 | 845 | 1,051 |
| E–7 | 11,027 | 765 | 801 | 10,688 | 768 | 800 | 339 | 674 | 831 |
| E–6 | 5,538 | 611 | 644 | 5,094 | 619 | 645 | 444 | 519 | 639 |
| E–5 | 847 | 452 | 518 | 371 | 513 | 543 | 476 | 403 | 499 |
| E–4 | 694 | 342 | 428 | 27 | 452 | 473 | 667 | 337 | 426 |
| E–3 | 449 | 301 | 366 | 2 | 370 | 370 | 447 | 301 | 366 |
| E–2 | 225 | 268 | 322 | 3 | 283 | 312 | 222 | 268 | 323 |
| E–1 | 120 | 258 | 296 | 1 | 536 | 634 | 119 | 256 | 293 |
| All enlisted | 26,657 | 784 | 828 | 23,717 | 826 | 862 | 2,940 | 445 | 550 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Unknown rank | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| All retirees | 35,232 | 1,010 | 1,067 | 31,922 | 1,058 | 1,109 | 3,310 | 542 | 667 |

---

Figures include retirees receiving payment from DOD and have not been adjusted to DOD budget figures.
Those retirees receiving a net dollar amount of zero are not included in the average net. Likewise for average gross.
"Number" is the actual number of retirees receiving payment from DOD with the corresponding rank. It is not necessarily the number used in the average annuity calculations.
"Monthly net retired pay" is the amount chargeable to the appropriation after deducting survivor payments, dual compensation reductions, VA payments, and the like, but before making individual deductions such as for income taxes or savings bonds.

Fiscal year (1982) figures are preliminary and subject to minor adjustments.

The principal, though by no means entire, topic of discussion is the entitlement to full retirement benefits immediately upon the completion of 20 years of service. Other issues include implementing a member contribution and integration of military retirement with social security.

### *(1) Twenty-Year Retirement*

Of the nine separate studies which have recommended revisions of the military retirement system (the report of the 5th Quadrennial Review of Military Compensation (5th QRMC) will bring the total to 10), none has proposed that military personnel should not qualify for some form of retirement benefits after 20 years of service. Most, in fact, have recommended that members be entitled to benefits with fewer than 20 years of service.

Historically, the main concern has been maintaining the "youth and vigor" of the armed services, in other words, their physical and mental stamina and agility. Presumably liberalized voluntary retirement provisions (as well as the judicious use of nonvoluntary retirement) serve the purpose of weeding out those older members, and thereby reducing the overall age of the services.

This presumption is disputed on a number of levels today. First, is the premise that age is an accurate measure of physical fitness, and the members in their forties are qualitatively less fit for their duties than their younger counterparts. In fiscal year 1982, the average ages of officers and enlisted persons retiring on nondisability pay were 45.5 and 41.7 respectively according to the DoD Office of the Actuary. Many studies of physiological traits show that though physical abilities decline with age, the decline is gradual at least until the fifties or sixties. Even at those ages, individual differences lead to wide variances in performance.[30] In addition, as with the population as a whole, a lengthening lifespan has changed the nature of age as a measure of physical deterioration.

Second, critics have disputed that military service today puts the same premium on physical stamina that it once did. In 1865, for example, 90.4 percent of military enlisted personnel were engaged in ground combat and general duty occupations. By 1963, that segment has dropped to 14 percent by some estimates, and nearly 86 percent of enlisted positions could be characterized as white or blue collar.[31] A General Accounting Office (GAO) analysis conducted in 1978 estimated that 81 percent of enlisted members and 30 percent of the officers who retired in fiscal year 1975 were not assigned to combat-related jobs at any time during their careers.[32] If the sole justification for "youth and vigor" is the rigors of battlefield service, then there seems to be a need to at least reassess this factor in view of the changing nature of warfare and military service.

---

[30] President's Commission on Military Compensation (PCMC). April 1978. pp. 53–54.

[31] Ibid.

[32] U.S. General Accounting Office. The 20-Year Retirement System Needs Reform; Report to the Congress by the Comptroller General of the United States. FPCD-77-81, Mar. 13, 1978. Washington, 1978. p. 10.

TABLE 4.—OCCUPATIONAL DISTRIBUTIONS OF DOD ENLISTED POSITIONS

[In percent]

| Occupation | Year— | | | | | | |
|---|---|---|---|---|---|---|---|
| | 1865 | 1918 | 1945 | [1] 1953 | [1] 1957 | 1960 | [1] 1963 |
| White-collar occupations | 3.9 | 16.6 | 33.0 | 37.4 | 39.9 | 47.2 | 42.2 |
| Professional-managerial | 3.0 | 5.4 | 10.4 | [2] 16.8 | [2] 20.7 | 12.8 | [2] 22.3 |
| Technical | .2 | 6.4 | 10.4 | | | 17.5 | |
| Administrative and clerical | .7 | 4.8 | 12.2 | 20.6 | 19.2 | 16.9 | 19.9 |
| Blue-collar occupations | 5.7 | 43.8 | 36.5 | 45.3 | 45.0 | 36.6 | 43.6 |
| Mechanics and repairpersons | .1 | 8.1 | 15.9 | 22.3 | 24.9 | 20.3 | 24.5 |
| Other craft workers | .5 | 12.3 | 7.3 | 6.6 | 7.4 | 6.2 | 7.2 |
| Services, operations, laborers, and miscellaneous [3] | 5.1 | 23.4 | 13.3 | 16.4 | 12.6 | 10.1 | 11.9 |
| Ground combat and general duty occupations | 90.4 | 39.6 | 30.5 | 17.3 | 15.1 | 16.3 | 14.1 |
| Total classified by occupation | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

[1] Data from Harold Wool, "The Military Specialist" (Baltimore: Johns Hopkins University Press, 1968), table III-3, p. 42. All other data are from Wool, table IV-1, p. 52.

[2] Combined totals shown due to differences in classification schemes. Totals for years shown (1953, 1957, and 1963) are for "Electronics" and "Other Technical."

[3] Miscellaneous equal 1 percent for 1953; includes aerial gunners but include in blue collar.

Notes on coverage: 1865—Union Army only. 1918—Army and regular Navy enlisted personnel only. 1945, 1960—Total military force. 1953, 1957,1963—DOD enlisted position only (including musicians).

Source: Report of the President's Commission on Military Compensation.

In fact critics have suggested that a premium might well be put on experience instead of youth, and that the incentives should be geared toward exacting a longer commitment. Two studies, the Hook Commission (1948) and the Defense Manpower Commission (DMC) (1976) have recommended that a 30-year career be established as the norm. The President's Private Sector Survey on Cost Control (PPSSCC) (1983) recommended delaying receipt of benefits until 30 years from the date of entry to the service, a proposal also set forth in the Retirement Modernization Act (RMA) in 1974. The RMA also recommended that the multiplier used to establish retired pay be increased to 3 percent (from the current 2.5 percent) for those serving more than 25 years.

The compensation of military personnel for "combat-related" jobs though, has been only half the argument for enhanced retirement provisions. It is but one component of the so-called *x* factor. The *x* factor represents those aspects of military service which differ from civilian employment. These include: The inherent dangers and risks associated with warfare; but also, periodic (and often involuntary) relocations and separations from family; and, finally a sacrifice of individual freedom, both during and potentially following active duty service (since members are subject to recall at any time).

Some critics have argued that on average, military life is not sufficiently different from civilian occupations to justify particularly the 20-year retirement provision. However, even allowing that retired pay could compensate for the *x* factor of military life, as the 1st QRMC (1969) pointed out in its report, unusual or dangerous duty assignments are not uniform across all members of the services. Thus, enhanced and deferred compensation for all members is an inefficient way to reward unusual service required of some.

In the wake of such criticism, at least one study has proposed to reward those who do serve in unusually difficult or dangerous assignments with immediate retirement benefits after less than 30 years of service. The Defense Manpower Commission (1976) suggested that added retirement point value be given to certain jobs according to their combat characteristics. Retirement points would be accumulated at a rate of 1/365 for each day in the assignment.

A focus on cost effectiveness and equity has led the majority of the studies to recommend earlier vesting for service members. Nearly 65 percent of all officers and 89 percent of all enlisted personnel leave the service prior to serving for 20 years. These service members never receive a military retirement benefit, although they may receive separation pay, and have acquired social security credits. In the private sector, most employees vest in plans after 10 years according to ERISA standards. Five studies have recommended that benefits be vested after 10 or 12 years of service. One, the Retirement Modernization Act (1974), suggested a 5-year figure. All recommended that the entitlement be to an annuity deferred until retirement age, usually 62. In the interests of encouraging full career service in the military, many suggested gradual increases in the multiplier for determining retirement pay. Most would allow early payment of benefits to a retired member, but would apply some percentage reduction to that early benefit.

The concerns are twofold. As indicated in a 1978 GAO study, the emphasis put on retirement benefits by longer serving members often leads to management retaining them regardless of the needs of the service until at least early retirement (20 years' service)[33] Conversely, the combined forces of familial and financial obligations often leads to a valuable and skilled member retiring once he has become entitled to retired pay, to take advantage of private sector wages combined with his retired pay. This leads to a situation were the services may well not have received the full value of its training investment in that individual.

### *(2) Member Contributions*

Military personnel do not contribute toward their retirement. They do, however, pay social security taxes, and, in order to participate in the survivor benefit program offset a certain percentage of retired pay. There has been some suggestion that members be required to make contributions to their retirement benefits. In the past some have argued that military pay is depressed by an imputed contribution toward retirement. However recent pay adjustments have aimed at bringing military pay into line with that for comparable civilian occupations. Several studies, such as the 3d QRMC (1976) have conclusively disputed the contention that military pay includes any imputed contribution for retirement.

Only two of the nine major studies of military compensation have suggested that members be required to contribute to the military retirement system. The prime argument for military personnel to contribute toward their retirement is, of course, to reduce the cost of the program to the Federal Government. In addition, cost sharing is often thought to be mutually advantageous to both employer and employee by making both more aware of their rights and responsibilities as regards compensation.

---

[33] Ibid., p. 16.

By one estimate, the savings of such a change to the system, however, are not great. By requiring a 7-percent contribution by personnel, savings would amount to about $40 billion through fiscal year 2000, or about 8 percent of the total costs of the disability and nondisability program.[34]

The costs to the individual service member are equally prohibitive, unless a compensating increase in pay were instituted to offset the cost of the deduction. Even if such a raise were given (at a significant cost to the Federal Government), the perceived erosion in benefits could pose a problem. In addition, though most public sector employees do make contributions to their retirement plans, fewer than 10 percent of private sector plans are contributory.[35]

### *(3) Integration With Social Security Benefits*

In 1956, the Servicemen's and Veterans' Survivor Benefit Act (Public Law 84-881) extended social security coverage to persons having to perform military service. This was to remedy gaps in social security protection brought about by required service. Gratuitous wage credits were extended for military service between 1940 and 1956. Since that time both members and the Federal Government (as employer) have made contributions to the social security system.

Since the institution of social security coverage for military personnel, military retirement benefits have been paid without any offset for social security, unlike 86 percent of private sector plans. The combination, for retirees with long service, has resulted in a total after-tax income in excess of 90 percent of active duty income.[36]

Several studies of the military retirement system have suggested that some offset be implemented. Proposals have ranged from a dollar-for-dollar offset for the amount of social security coverage attributable to military service, to an overall reduction in military pay in recognition of the contribution of social security benefits to retirement income security.

The obvious objection to such proposals to integrate the two benefits is that it would be perceived as an erosion of benefits.

### (E) CONCLUSIONS

Military retirement is among the small group of fast-growing entitlement programs relatively untouched in the past few years of budget cutbacks. It is unlikely that in the current economic climate of budget cutbacks, military retirement benefits will remain the same. The report of the 5th QRMC is due in February 1984, and preliminary reports have indicated that it will propose substantive changes in the calculation of benefits, and most likely on a prospective basis so as not to jeopardize the benefits to those personnel currently receiving or working toward retirement. In all probability Congress will not address any comprehensive reforms of the military retirement system in 1984 due to the elections.

---

[34] U.S. Congress. Senate. Committee on the Budget. Financing Work-Related Entitlement Programs. Senate Print No. 98-48, 98th Cong., 1st Sess. Washington, U.S. Govt. Print. Off., 1983. pp. 370-371.

[35] Ibid.

[36] PCMC. p. 30.

## D. RAILROAD RETIREMENT SYSTEM

### 1. Overview

The railroad retirement system is a federally managed retirement system covering employees in the rail industry, with benefits and financing coordinated with the social security system. The system was authorized in 1935, prior to the creation of social security, and it remains the only federally administered pension program for a private industry. It covers hundreds of railroad firms and distributes age and disability benefits to retired employees, their spouses, and survivors. Benefits are financed through a combination of employee and employer payments to a trust fund, with the exception of dual vested or so-called "windfall" benefits, which are paid for through general revenues out of a separate account. Currently, about 1 million retirees receive railroad benefits, and payments to these beneficiaries reached approximately $8 billion in the period between October 1982 and September 1983. Rail employment, after dropping heavily from about 500,000 in mid-1981 to 380,000 in March 1983, has stabilized at a level hovering around 400,000.

The railroad retirement system was the subject of considerable congressional attention during 1983. Early in the year it became apparent that the poor financial condition of the railroad retirement trust fund, due to the major decrease in rail employment and hence payroll tax revenue, would require a 40-percent cut in retiree's pension benefits on October 1. To avert this drastic benefit reduction, Congress prompted rail labor and management to collectively negotiate a financing package to restore solvency to the rail trust fund. The product of that effort, with some modification, was enacted in August as the Railroad Retirement Solvency Act of 1983. The act includes a number of significant tax and benefit revisions, as well as a reordering of the technical relationship between social security and the railroad retirement account. The legislation is predicted to guarantee the financial solvency of the railroad retirement fund at least through the 1990's.

### 2. Historical Development

In the final quarter of the 19th century, railroad companies were among the largest in America, and were marked by a high degree of organizational centralization and integration. Occupationally, it was in the rail industry that the first industrial pension was established in 1874, and sophisticated seniority systems were developed early to cultivate a stable and continuous work force. By the mid-1920's more than 80 percent of all rail workers were covered by pension plans.

In the early 1930's the financial integrity of these pension plans, and their utility to rail workers, were in severe question. On the one hand, the commercial success of the rail industry peaked in the period between 1900 and 1920, and rail employment decreased significantly in the 1920's, due to automation and industry maturation.

Unemployment was greatly exacerbated by the depression, and hundreds of thousands of younger workers were laid off. The rail labor force was characterized by an unusually large proportion of older workers, who remained in their jobs due to rigid seniority structures, and insecurity about retiring to little or no income. Rail pension plans were for the most part very poorly constructed, and rarely provided benefits to workers in retirement. Credits earned with one firm were not readily transferable to other employers, and there was no regulation of plan terminations, which were frequent. Pension funds were chronically underfinanced, and most could not stand the financial exigencies of the depression.

Beginning in the middle of the 19th century with land grants, and then with the Interstate Commerce Act, the railroad industry has been treated as a unified transportation system with public, national obligations. This tradition of Federal regulation of the railroads, in conjunction with the inadequacy of rail pensions and the social desirability of providing an incentive for older workers to retire and thereby reduce unemployment, led to the enactment of the Railroad Retirement Act of 1934. In addition to alleviating massive unemployment, the railroad retirement system was to serve as a model for social security, and to promote safety and efficiency in the rail industry.

The original railroad retirement system was structured to provide annuities to retirees based on rail earnings and length of service. Benefits were disbursed for retirees at age 65, although workers with 30 years of service could retire at 60, with a reduction in payments. The original disability provisions were very stringent, and little was provided for dependents and nothing for spouses.

Throughout its history, the railroad retirement system has been modified many times by Congress. In the late 1940's and 1950's benefits were liberalized, and the railroad retirement system was brought into closer conformity with social security. For instance, in 1946, benefits were extended to survivors, based on combined railroad and social security covered employment. This extension represented a concern for the social goal of providing income security in old age, or social insurance, rather than simply rewarding career performance. In 1951, a financial interchange was established between social security and the railroad retirement system which coordinated payments between the two systems.

The Railroad Retirement Act of 1974 fundamentally reorganized the railroad retirement system, and established the outline of its present day organization. Most significantly, the legislation created a two-tier benefit structure in which tier I serves as an equivalent to social security, and tier II parallels a private pension. Tier I benefits are computed on credits earned in both rail and nonrail work, while tier II is based solely on railroad employment. The total benefit amounts to traditional railroad annuities, and eliminates duplicate coverage for nonrail service by both social security and the railroad retirement system.

A major provision in the 1974 legislation is that which phases out dual vested or "windfall" benefits for those workers who qualify for both railroad and social security benefits. In the past, an individual who met service requirements in railroad retirement, yet also had earned credits in social security covered employment, received duplicate retirement coverage, and was compensated at a higher rate than employees who worked exclusively in either rail or nonrail employment. Further, dual benefits were a financial drain on the railroad retirement fund, which was responsibile for paying the "windfalls" to retirees.

The 1974 legislation eliminated the windfall for individuals not vested (defined as 10 years rail employment) by December 31, 1974, but was not retroactive. Employees and retirees who were vested by the end of 1974 will continue to receive a windfall, financed by general revenues. These benefits, however, will not increase due to social security covered employment undertaken after 1974, nor will social security COLA's be applied to them.

### 3. Changes in 1981

The 1970's were a decade of poor performance in the rail industry, and by 1980, the retirement trust fund was faced with the prospect of insolvency. The primary reason for this was declining rail traffic, and hence declining employment. Ever since the end of World War II, the worker/beneficiary ratio has been decreasing, as described by the table below:

TABLE 5.—EMPLOYEES IN THE RAILROAD INDUSTRY AND BENEFICIARIES OF THE RAILROAD RETIREMENT SYSTEM SINCE 1945

[In thousands]

| | Average employment | Beneficiaries |
|---|---|---|
| Year: | | |
| 1945 | 1,689 | 210 |
| 1950 | 1,421 | 461 |
| 1955 | 1,239 | 704 |
| 1960 | 909 | 883 |
| 1965 | 753 | 930 |
| 1970 | 640 | 1,052 |
| 1975 | 548 | 1,094 |
| 1976 | 540 | 1,100 |
| 1977 | 545 | 1,107 |
| 1978 | 542 | 1,100 |
| 1979 | 554 | 1,093 |
| 1980 | 531 | 1,084 |
| 1981 | 505 | [1] 999 |
| 1982 | [2] 446 | [3] 988 |
| 1983 | [4] 402 | [5] 981 |

[1] July 1981.
[2] January through October 1982.
[3] July 1982.
[4] November 1983.
[5] July 1983.

This longer term financing problem was aggravated by the fact that congressional appropriations for "windfall" benefits were far from sufficient to pay for those benefits, and the difference was paid from the railroad trust fund.

To redress the problem of solvency, Congress included railroad retirement financing provisions in both the Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35) and the Economic Recovery Tax Act of 1981 (Public Law 97-34). These amendments raised payroll taxes on employers and employees, modified benefits, created a separate account for "windfall" benefits, and provided the railroad retirement trust fund with authority to borrow funds from the General Treasury, when near term cash flow difficulties arise.

The payroll tax increases were applied to the tier II, or railroad pension, portion of the retirement system. Tier I taxes remained identical to social security taxes. For the tier II taxable payroll, employees were required to increase their contribution from 9.5 to 11.75 percent. Employees assumed a tier II tax of 2 percent. Additionally, the Railroad Retirement Board was given the authority to borrow money from the Treasury during any month in which the trust fund cannot pay full benefits to retirees. These loans, which must be repaid with interest, are really an advance by the Treasury against the sums the Social Security Administration pays to the rail trust fund in June, under the financial interchange.

This limited borrowing authority is linked to a "benefit preservation" provision which requires that in any fiscal year that loans will exceed 50 percent of estimated financial interchange revenue, rail labor and management, and the President, must submit refinancing proposals to Congress. Further, the Railroad Retirement Board (RRB) is required to announce the method it will employ to reduce benefits in any month inadequate funds preclude full payment, with highest priority afforded tier I benefits.

The 1981 amendments were predicted to assure the solvency of the railroad retirement system into the future, based upon moderate assumptions about rail employment. Unfortunately, the recession devastated the railroad industry in the final quarter of 1982, and by March 1983, employment had fallen to 380,000. In response to this decline, and its implications for the trust fund, the RRB reported in February 1983, that it expected its loans from the Treasury would surpass 50 percent of expected financial interchange income in fiscal year 1984.

### 4. Changes in 1983

Early in 1983, rail labor and management collectively negotiated a new financing package and submitted it to Congress. If nothing was accomplished by October 1, the RRB announced that a 40-percent reduction in tier II benefits, or about $55 monthly, on average, would have been exacted from retiree's benefits.

The package rail labor and management introduced included employee and employer payroll tax increases, benefit reductions, and Federal contributions. The proposal were embodied in H.R. 1646, which was modified a number of times before becoming law. The initial package included $9.9 billion in savings over the 5-year period between fiscal years 1984 and 1988. The burden was distributed to four constituencies: The Federal Government assumed 59 percent of the costs, rail retirees 22 percent, employers 11 percent, and employees 8 percent. The House Ways and Means Committee modified the original package, and notably diminished the Federal role in solving the trust fund crisis. As modified, the House bill required the Government to contribute 44 percent, retirees 24 percent, employers 13 percent, and employees 11 percent.

The Ways and Means Committee reported H.R. 1646 on July 1, and on August 1, the bill was passed, with three floor amendments. On August 2, the Senate adopted the legislation without amendment, and on August 12, H.R. 1646 was signed by the President, and became Public Law 98-96.

The key provisions of the Railroad Retirement Solvency Act of 1983 are summarized below.

### (A) BENEFITS

The most significant benefit change is the COLA offset provision, which requires that the next 5 percent of tier I (social security) COLA increases will be subtracted, dollar for dollar, from tier II (railroad pension) benefits. On January 1, 1984, the 3.5 percent social security (tier I) COLA was deducted from retiree's tier II benefits. Essentially, this provision erased the social security COLA increase for railroad retirees. In 1985, the social security COLA is projected to be 4.4 percent. However, railroad retirees will receive only a 2.9 percent COLA, due to the remaining 1.5 percent offset not accounted for in 1984. This provision is expected to produce savings of about $1 billion over the next 5 years.

The so-called 60/30 benefit, which allows employees with 30 years of service to retire at age 60 without benefit reduction, is to be phased out as a result of the legislation. Employees with 30 years of service, who attain the age of 60 before July 1, 1984, may retire with full coverage. Employees who reach age 60 between July 1, 1984 and December 31, 1985, will lose 10 percent of their benefits if they retire before 62. 60/30 candidates after January 1, 1986, will suffer a 20-percent loss in benefits if they choose to retire before 62.

Eligibility for spousal benefits were revised. In the past, a spouse was ineligible unless the employee and spouse were living under the same roof, or if the spouse was supported by the employee, on the date of application for spousal benefits. This provision was terminated by the legislation.

A number of other benefit changes were included in the act, most of which brought the railroad retirement system into greater uniformity with social security.

### (B) TAXES

Beginning January 1, 1984, three annual 0.75 percent payroll tax increases will be collected from rail employees and employers. In 1983, the tax rate on employees was 2 percent; currently it is 2.75 percent, in 1985 it will be 3.50 percent, and in 1986 it will be raised to 4.25 percent of taxable payroll. In 1983, employer payroll taxes equaled 11.75 percent; these are to be increased 1 percentage point in 1984, 1985, and 1986. In 1986, employer payroll taxes will hence equal 14.75 percent of taxable payroll. Employer payroll tax deposits have been accelerated to conform to other Federal payroll tax deposit schedules, and beginning in 1985, rail taxes will be applied to earnings on an annual, rather than a monthly basis, as is the case currently. Railroad retirement taxes for 1984 are summarized in the table below:

TABLE 6.—1984 RAILROAD RETIREMENT TAXES

| | Tax rate | Taxable monthly earnings |
|---|---|---|
| Tier I: | | |
| Employees | [1] [2] 6.70 | $3,150 |
| Employers | [2] 7.00 | 3,150 |
| Tier II: | | |
| Employees | [2] 2.75 | 2,350 |
| Employers | [2] 12.75 | 2,350 |

| | Maximum monthly regular taxes | | |
|---|---|---|---|
| | Tier I | Tier II | Total |
| Employees | $211.05 | $64.63 | $275.68 |
| Employers | 220.50 | 299.63 | 520.13 |

[1] Reflects the 0.3 percent credit for employees during 1984.

[2] Percent.

Source: Railroad Retirement Board.

The railroad unemployment insurance tax paid by employers will be levied on the first $600 of monthly earnings, which is 50 percent more than the old $400 wage base. On July 1, 1986, a temporary unemployment tax will be collected from employers to repay a debt owned by the unemployment account to the retirement account. The tax will begin at 2 percent of the first $7,000 in annual earnings, and will increase in yearly increments of 0.3 percent until 1990, when the tax will be terminated.

Tier II benefits and vested dual or "windfall" benefits are now subject to Federal income taxation under the same guidelines as private pension earnings—i.e., to the extent the income exceeds the employee's contributions. The revenues collected from this taxation will be transferred to the rail trust fund to finance benefits payments, through 1989. After that point, the revenues will remain with the Treasury.

### (C) OTHER CHANGES

One critical cause of cash shortages in the railroad retirement trust was the technical structure of the financial interchange—in the past, social security reimbursed the rail trust fund each June to establish financial equality between the two systems. The problem with this arrangement was that the transfer of funds, accomplished annually, led to liquidity shortfalls in the rail trust fund. The 1983 legislation resolved this difficulty by providing the rail trust fund authority to borrow from the Treasury against outstanding debts owed by social security, thus making current the interchange between the two systems.

Another financial difficulty was resolved by a provision authorizing the Treasury to pay, in three yearly installments, approximately $2 billion for shortfalls in "windfall" appropriations for the fiscal years 1975 to 1981. These payments began January 1, 1984. A further technical change was accomplished by creating a separate account for social security equivalent benefits.

The legislation included a provision requiring the RRB to produce a yearly report, beginning July 1, 1985, documenting the financial status of the railroad retirement system, and any recommendations for legislative changes that may be necessary. On the Senate floor, Aging Committee Chairman Heinz requested that the RRB report to Congress by October 1984, on the effect of the COLA offset provision on railroad retirees, and the means through which this benefit reduction can be repaid in the future.

It is also important to note that many of the changes enacted as part of the Social Security Amendments of 1983, discussed in chapter 3, apply to the tier I component of the railroad retirement system. Specifically, the 1983 COLA increase was delayed 6 months from July 1 to January 1, 1984, and tier I benefits are subject to Federal income taxation if adjusted gross income is in excess of $25,000 for individuals and $32,000 for couples. Tier I payroll taxes increased from 6.7 to 7 percent on January 1, 1984, and will increase to 7.05 percent in 1985, and to 7.15 percent in 1986. A one-time tax credit of 0.3 percent of wages will be available in 1984 to employees.

### 5. ASSESSMENT

Overall, the Railroad Retirement Solvency Act of 1983, through a combination of tax increases, benefit adjustments, and Federal assistance should guarantee the solvency of the railroad retirement system through the 1990's, even under pessimistic employment assumptions. Further, it is expected that in the future, the worker/retiree ratio will increase, as the number of retirees has reached its peak, and should decline in the future.

The legislation is not without flaws though, and it is important to point out some of the weaknesses in the law. For instance, the COLA offset provision could not be accomplished if the tier II benefit component were truly an industry pension, and subject to ERISA regulations. To take funds from tier II to offset increases in tier I benefits partially undermines the basic assumption of the 1974 reorganization. The abrupt phaseout of 60/30 benefits jeopardizes the plans of older rail employees who had conceived their retirement on benefit assumptions that have been rendered invalid. To change the rules midstream, and with such rapidity, is inequitable to employees nearing retirement. Finally the tax treatment of "windfall" benefits as equivalent to pension benefits is inconsistent with the fact that "windfall" payments accrue from social security coverage. "Windfall" benefits should be taxed like social security benefits, not like returns from a private pension.

To address the first of these problems, Senator Heinz introduced S. 1934, a bill to repeal the second phase of the COLA offset (1.5 percent, scheduled for January 1, 1985) if trust fund reserves are adequate to finance 30 percent of projected 1985 outgo. The rationale behind the bill is that if rail employment increases, due to economic recovery, the second phase of the COLA offset may prove unnecessary.

Despite its patchwork character, the Railroad Retirement Solvency Act seems to have resolved the short-term financing crisis in the railroad retirement system. Without the complex combination of tax increases, benefit cuts, and financial changes, current retirees would have lost 40 percent of tier II benefits in 1983, and as much as 80 percent in 1984. The final package seems to have restored the system to a position of financial solvency, and it is unlikely it will be the subject of significant congressional attention in 1984.

# Chapter 5

# ASSETS: SAVINGS AND CAPITAL ACCUMULATION PLANS

## OVERVIEW

As a result of the Economic Recovery Tax Act of 1981 (ERTA, Public Law 97-34), major changes in the Tax Code took place in 1982 affecting retirement savings. It was not until 1983, however, that the full impact of these changes was realized. By the end of the year it was clear that individual retirement arrangements (IRA's) were being utilized at a rate that far surpassed expectations.

The popularity of IRA's has prompted several proposals to encourage their further growth and increase their flexibility. Interest has been shown in indexing the limits on annual contributions to an IRA, and legislation has been introduced which would allow the use of IRA's or IRA-like tax-deferred savings devices for other large personal expenses, such as the purchase of a home, financing college education, or paying for medical expenses.

This was also the year in which new payroll-based tax credit employee stock ownership plans (PAYSOP's) became available as another vehicle designed to encourage ownership of employer stock by employees. Proposals have been made to further expand the use of employee stock ownership plans (ESOP's) generally. Debate continued, however, over the appropriateness of ESOP's when used by an employer as the sole or principal means of providing retirement income for employees.

## A. INTRODUCTION

Since 1981, public policy has placed considerable emphasis upon stimulating the growth of the national economy by encouraging investment. Any increase in investment in the economy must be accompanied by a corresponding increase in saving. Total national saving comes from three sources: Individuals save out of their personal income; businesses retain, and thereby save, some of their profits; and governments save when they run a budget surplus or dissave when they run a budget deficit. It is total national saving that supports total investment in the economy. A portion of saving flows into residential investment, investment in inventories, and net foreign investment (exports minus imports). The remainder is available to finance business purchases of plant and equipment.[1]

---

[1] See: U.S. Library of Congress. Congressional Research Service. Capital, Credit, and Crowding Out: Cycles and Trends in Flows of Funds Over Three Decades, by William Jackson. CRS Report No. 82-142E. Washington, 1982.

This chapter on savings will, however, focus exclusively upon personal savings as a potential source of income to individuals in retirement. It is important to stress at the outset that accurate data on savings patterns of individuals are scarce, and the opinions of experts interpreting the data are often controversial. We do know that the rate of personal saving in the United States has tended to be relatively constant, i.e., there have been cyclical changes during which the personal saving rate moves up and down, depending on the economy, but by and large, personal saving rates have fallen within rather narrow bounds. The following table shows personal saving as a percent of disposable personal income from 1929 to 1982.

TABLE 1.—*Personal saving as a percent of disposable personal income, 1929–82*

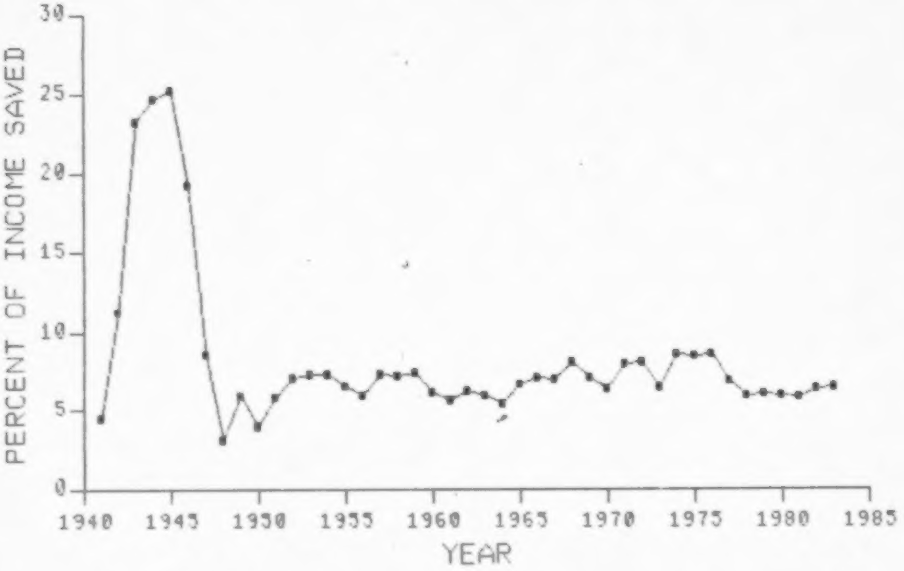
| Year: | |
|---|---|
| 1929 | 4.0 |
| 1933 | −2.0 |
| 1939 | 3.1 |
| 1940 | 4.5 |
| 1941 | 11.2 |
| 1942 | 23.3 |
| 1943 | 24.7 |
| 1944 | 25.2 |
| 1945 | 19.2 |
| 1946 | 8.6 |
| 1947 | 3.1 |
| 1948 | 5.9 |
| 1949 | 4.0 |
| 1950 | 5.8 |
| 1951 | 7.1 |
| 1952 | 7.3 |
| 1953 | 7.3 |
| 1954 | 6.6 |
| 1955 | 6.0 |
| 1956 | 7.3 |
| 1957 | 7.2 |
| 1958 | 7.4 |
| 1959 | 6.2 |
| 1960 | 5.6 |
| 1961 | 6.3 |
| 1962 | 6.0 |
| 1963 | 5.4 |
| 1964 | 6.7 |
| 1965 | 7.1 |
| 1966 | 7.0 |
| 1967 | 8.1 |
| 1968 | 7.1 |
| 1969 | 6.4 |
| 1970 | 8.0 |
| 1971 | 8.1 |
| 1972 | 6.5 |
| 1973 | 8.6 |
| 1974 | 8.5 |
| 1975 | 8.6 |
| 1976 | 6.9 |
| 1977 | 5.9 |
| 1978 | 6.1 |
| 1979 | 5.9 |
| 1980 | 5.8 |
| 1981 | 6.4 |
| 1982 | 6.5 |

Source: Department of Commerce, Bureau of Economic Analysis.

Except for the World War II period, when savings were as high as 25 percent of personal income because production focused on the war effort, the saving rate has more or less fluctuated between 5 to 8 percent of disposable income during the postwar period.

CHART 1

PERSONAL SAVING RATE
1940-1982



SOURCE: DEPARTMENT OF COMMERCE, BUREAU OF ECONOMIC ANALYSIS

Cyclical changes, however, can also be important. Since 1975, for example, when the personal saving rate was 8.6 percent of disposable income, it declined to 6.5 percent of disposable income in 1982. A number of factors have been cited to explain the recent low saving rate. These include the high proportion of the work force consisting of younger people, who tend to save less; the increased number of two-earner households; and the efforts to maintain consumption patterns in the face of inflation. Another factor cited has been the failure of tax policy to adequately reward saving, while making consumer debt relatively more attractive because of the tax deductibility of interest on consumer debt.[2]

The recent cyclical downturn aside, however, it is also true that personal saving in the United States has been substantially below the saving rate of other industrialized countries. The following table and chart illustrate that in the other industrialized countries of the world, individuals tend to save two or three times as much of their personal income as do Americans. (This disparity is clearly visible despite technical differences in definitions of saving and investment across countries.)[3]

---

[2] U.S. Board of Governors of the Federal Reserve System. Public Policy and Capital Formation. Washington, U.S. Govt. Print. Off., 1981, pp. 100-162. See also: U.S. Library of Congress. Congressional Research Service. Saving and Rate of Return Incentives: Estimates of the Interest Elasticity of Personal Saving, by William Jackson. CRS Report No. 81-198E. Washington, 1981.

TABLE 2.—*Personal saving rates in the United States and other countries, 1981*[1]

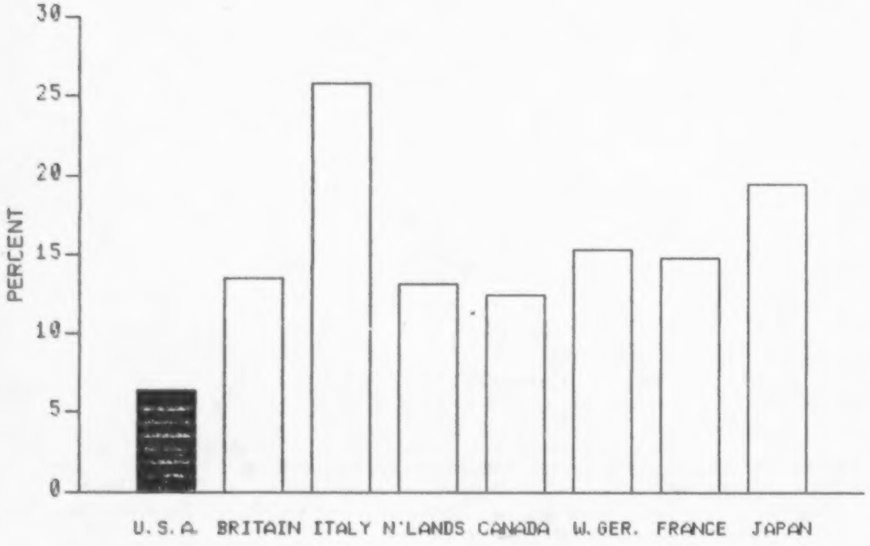
| | *Percent* |
|---|---|
| United States | 6.4 |
| France | 14.8 |
| West Germany | 15.3 |
| Italy | 25.7 |
| Netherlands | 13.1 |
| Great Britain | 13.5 |
| Japan[2] | 19.4 |
| Canada | 12.4 |

[1] Ratio of savings to disposable personal income (percent).
[2] 1980.

Source: U.S. Department of Commerce, International Economic Indicators, vol. VII, No. 4, December 1982.

CHART 2

PERSONAL SAVING RATES
IN THE UNITED STATES AND OTHER COUNTRIES, 1981



SOURCE: U.S. DEPARTMENT OF COMMERCE, INTERNATIONAL ECONOMIC INDICATORS, VOL. 8, NO. 4, DECEMBER 1982

## B. RELATIONSHIP BETWEEN AGE AND SAVINGS

For many years, a so-called life-cycle theory of saving has been advanced by some analysts, which has postulated that individuals save very little as young adults, increase their savings in middle age, and then live off those savings in retirement, i.e., dissave. Thus, according to this theory, individuals entering retirement age would not be expected to save any more of their income, and they would be expected to deplete the savings they had previously accumulated.

---

[3] U.S. Board of Governors, pp. 59–74.

The truth of the matter is that accurate, current data about the relationship between age and savings is not available. There are problems inherent in conducting surveys of individuals and asking what their assets are and how much income they derive from those assets. Such surveys, moreover, are expensive.

Nevertheless, two surveys of this subject were done in the 1960's and 1970's, the Survey of Changes in Family Finances (SCFF) commissioned by the Federal Reserve Board, and the Department of Labor's Personal Consumption Expenditure Surveys (CES).

TABLE 3.—SURVEY OF CHANGES IN FAMILY FINANCES: SAVINGS AS A PERCENT OF TOTAL INCOME [1]

| | Age of head | | | | | |
|---|---|---|---|---|---|---|
| | Under 35 | 35 to 44 | 45 to 54 | 55 to 64 | 65 plus | All |
| Total assets | 6.56 | 5.84 | 8.04 | 3.51 | 5.98 | 6.17 |
| Business assets | 1.75 | −.57 | 1.21 | −1.92 | 1.43 | .36 |
| Liquid assets | −.10 | 3.58 | 6.33 | 3.78 | 5.16 | 3.73 |
| Checking deposits | .12 | .28 | .83 | .74 | .98 | .54 |
| Savings accounts | .35 | 3.01 | 4.49 | 2.60 | 4.26 | 2.74 |
| Savings bonds | .13 | .29 | 1.01 | .43 | .22 | .46 |
| Investment assets | 4.37 | 2.19 | −.62 | 1.12 | −1.01 | 1.41 |
| Miscellaneous assets | .05 | −.11 | .07 | −.50 | −.18 | −.10 |
| Retirement assets | .50 | .76 | 1.05 | 1.03 | .28 | .77 |
| Total debt | −14.84 | −3.25 | 2.99 | .39 | −4.75 | −3.64 |
| Home | −12.77 | −3.49 | 2.42 | .38 | .62 | −2.85 |
| Investment | 1.91 | 1.23 | .20 | .27 | −5.07 | −.62 |
| Personal | .16 | −.97 | .78 | −.35 | −.42 | −.12 |
| Installment | .46 | .52 | .99 | −.69 | .66 | .44 |
| Auto | .09 | .49 | .67 | −.29 | .10 | .24 |
| Nonauto | .55 | .03 | .33 | −.40 | .56 | .20 |
| Noninstallment | −.30 | −1.49 | −.21 | .34 | −1.08 | −.55 |
| Life insurance | −.32 | −.02 | −.02 | .09 | .12 | −.05 |
| Housing expenditures | 19.52 | 6.31 | 2.13 | 3.65 | −2.23 | 6.79 |
| Auto expenditures | 6.21 | 5.25 | 4.83 | 5.90 | 2.28 | 5.16 |
| Net financial investment | −8.27 | 2.59 | 11.03 | 3.90 | 1.23 | 2.53 |
| Total savings | 17.49 | 11.19 | 18.29 | 13.45 | 1.28 | 14.47 |

[1] Calculated from SCFF data tape (N=2,159). Income is the total income received in the calendar year by all members of the consumer unit before any payroll or income tax deduction.

Source: Wachtel, Paul. The Impact of Demographic Changes on Household Savings, 1950–2050. President's Commission on Pension Policy. Coming of Age: Toward a National Retirement Income Policy, technical appendix, Ch. 30.

These two surveys (tables 3 and 4) show that individuals do indeed tend to save more in middle age than they do in their youth or in old age. But the data also indicate that the elderly do continue to save at a rate that is not far from the national average, as shown by the saving rate by age of household head (table 5). There is little convincing evidence which shows that individuals generally exhaust or deplete their assets during retirement, and there is some opposing evidence which indicates that asset levels remain relatively constant during the retirement period.

TABLE 4.—CONSUMER EXPENDITURE SURVEY: SAVING AS A PERCENT OF BEFORE-TAX INCOME

| | Age of head | | | | | | |
|---|---|---|---|---|---|---|---|
| | Under 25 | 25 to 34 | 35 to 44 | 45 to 54 | 55 to 64 | 65 and over | Total |
| | Net changes in assets and liabilities | | | | | | |
| Survey: | | | | | | | |
| 1960–61 | 2.56 | 2.50 | 3.02 | 3.98 | 4.71 | 2.72 | 3.19 |
| 1972–73 | 5.92 | 8.36 | 8.18 | 7.75 | 9.37 | 5.62 | 7.22 |
| | Net changes in assets | | | | | | |
| 1960–61 | 11.90 | 14.54 | 8.39 | 7.52 | 5.99 | 2.00 | 8.39 |
| 1972–73 | 12.90 | 22.59 | 13.13 | 9.84 | 9.22 | 6.30 | 12.82 |
| | Net changes in liabilities | | | | | | |
| 1960–61 | 14.46 | 12.05 | 5.38 | 3.53 | 1.28 | 0.27 | 5.20 |
| 1972–73 | 18.82 | 14.61 | 4.99 | 2.09 | .15 | .68 | 5.60 |

Source: Wachtel, Paul. The Impact of Demographic Changes on Household Savings, 1950–2050.

TABLE 5.—*Saving rate by age of household head*

| | *Percent saving rate*[1] *1972–73* |
|---|---|
| Age of household head (years): | |
| Under 25 | −6.9 |
| 25 to 34 | 9.4 |
| 35 to 44 | 9.7 |
| 45 to 54 | 9.2 |
| 55 to 64 | 11.2 |
| 65 and over | 6.1 |

[1] Saving as percent of disposable personal income.

Source: Economic Report of the President, January 1979, p. 116.

A survey conducted in the summer of 1981 by Louis Harris & Associates and commissioned by the National Council on the Aging, Inc., found that even though the elderly had incomes only half as great as those between 18 and 54, the elderly seem to be coping almost as well. Louis Harris asked:

> How come? First, 66 percent of those 65 and over own their houses free and clear, while this is the case with only 12 percent of those between 18 and 54. Second, by any measure, the elderly are more frugal and experienced in the handling of their money. For example, in the last year, only 39 percent of elderly had to draw down on their savings to pay bills, while a much higher 52 percent of those under 65 had to do the same, even though both groups have the same number, 88 percent, who have a savings account

Surveys of savings and loan association depositors conducted by the U.S. League of Savings Associations in late 1981 and early 1982 confirm these findings that the elderly continue to save at relatively high rates; i.e., they save a high proportion of their income, but because income tends to decline with retirement the *flow* of saving from retirees also declines.[4]

Drawing on a nationwide random sample of more than 24,000 savings association depositors, questionnaire respondents were asked, among other things, to indicate their age, income, and the amount they expected to save in 1982. Table 6 summarizes these responses by age group against median income and median expected saving. The implied saving rate for each of the age groups clearly shows the sharp increase after age 45 that the life cycle of saving predicts and the decline in saving *flow* after age 65, even though the saving *rate* continues to increase.

TABLE 6.—THE LIFE CYCLE OF SAVING

| Age group | Median household income | Median expected household saving | Implied saving rate (percent) |
|---|---|---|---|
| 18 to 24 | $18,544 | $840 | 4.5 |
| 25 to 34 | 28,476 | 1,267 | 4.4 |
| 35 to 44 | 35,730 | 1,687 | 4.7 |
| 45 to 54 | 36,620 | 2,310 | 6.3 |
| 55 to 64 | 31,188 | 2,949 | 9.5 |
| 65 and over | 22,081 | 2,490 | 11.3 |

Source: U.S. League of Savings Associations, Economics Department, The All Savers Survey Project, 1981–82.

It must be emphasized, however, that savings and loan association depositors differ somewhat, particularly among the 65 and over age group, from the population at large. The median income of savings association depositors is higher in all age groups than either the population at large or the population of depositors in all financial institutions. This characteristic is especially prominent in the 65 and over age group. For this reason, savings association depositors are unlikely to conform as closely to the life cycle of saving as the population at large, particularly in the age group over age 65.

## C. ROLE OF SAVINGS IN RETIREMENT

### 1. ASSETS OF THE ELDERLY IN RETIREMENT

In January 1981, the Social Security Bulletin published a study by Joseph Friedman and Jane Sjogren analyzing the "Assets of the Elderly As They Retire." The study was based on a longitudinal analysis of 11,153 people age 58 to 63 in 1969 who had become 64 to 69 in 1975. The authors analyzed this group of people during that 1969–75 period to learn what types of assets were held by the elderly, how large were these assets, and how the assets changed as the people entered retirement.

Total assets include liquid assets (e.g., checking and savings accounts, stocks, bonds, and mutual funds), nonliquid assets (real estate and equity in businesses and professional practices) and home equity (the value of the home less any mortgage debt).

---

[4] Christian, James W. Tax Incentives for Saving: The Idea and the Evidence. Paper by Chief Economist, Staff Vice President and Director, Economics Department, U.S. League of Savings Associations, Chicago, Ill., 1982.

Nearly 90 percent of the group owned assets of some kind. The median value of the assets, however, was not large. Over the 1969-75 period, the assets values (in 1969 constant dollars) ranged from $19,000 to $21,000 for married men, $10,200 to $13,000 for nonmarried men, and from $8,800 to $9,600 for nonmarried women.

The distribution of the assets among the elderly was skewed. Although a large proportion of them had little or no assets, 4 to 5 percent had assets of more than $100,000 and another 8 to 9 percent had assets between $50,000 to $100,000. As one might expect, people with relatively higher incomes had larger amounts of assets than those with lower incomes.

Liquid assets were the most common type of asset held by older Americans. Nearly 80 percent of the sample population had some liquid assets. The amounts were small, however, with the median value being $3,000 to $3,600.

Nonliquid assets were held by less than one-third of the people.

But nearly two-thirds of the elderly owned a home, and more than 80 percent of the married men owned a home.

What is particularly interesting about this study is that there was no marked pattern of asset reduction over the 1969-75 period, which indicates that the group—as a whole—was not liquidating its wealth to meet retirement needs. Some asset liquidation did occur, nevertheless, among people in the lower income group who also had substantial assets to draw upon.

This study portrayed a rather bleak picture of the economic well-being of older Americans. Generally, it found that as people reach retirement age their incomes decrease, their property wealth is limited, and they can seldom be expected to rely on assets to maintain their previous standard of living. Although this is generally true, a small fraction of the elderly with incomes in the highest one-fourth of the group did have substantial asset wealth.

Data from a more recent survey show the distribution of wealth (assets) across the different age groups—although they provide no indication as to the distribution of asset values *within* different age bands. This survey was done in 1979 in conjunction with the design of the Department of Health and Human Services (HHS) survey of income and program participation (SIPP). For the 1979 survey, a national probability program of about 9,500 households was canvassed six times at roughly quarterly intervals on a wide range of income, program participation, and related social and economic matters. Detailed data on net worth were obtained at the fifth interview (or so-called "wave"), referring to holdings as of December 31, 1979. (About 7,000 households responded at that stage.) More limited net worth data were obtained in the second interview (wave). The results from these interviews are collected in table 7, taken from a paper by Robert B. Pearl and Matilda Frankel.[5]

The data are presented in terms of the age of the "reference person," who is generally the individual in whose name the living quarters are owned or rented.

---

[5] Composition of the Personal Wealth of American Households at the Start of the Eighties. Paper presented at the American Statistical Association Annual Meeting in Cincinnati, Ohio, August 1982. The following analysis of this data is taken from the same paper.

## TABLE 7.—WEALTH DISTRIBUTION OF HOUSEHOLDS, BY AGE OF REFERENCE PERSON: YEAR END 1979

| Age of reference person | Net worth | Total wealth | Assets | | | | | | | | | | | | Total unsecured debt |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Financial assets | | | | | | | Equity in: | | | |
| | | | Equity in own home | Equity in vehicles | Total | Cash, checking accounts | Savings account | Savings bonds | CD's, bonds, loans | Stocks, mutual funds | Equity in rental property | Own business | Own farm | Household goods and other assets | |
| Percent distribution by category of assets: | | | | | | | | | | | | | | | |
| Under 35 | 100.0 | 111.8 | 42.0 | 7.1 | 16.9 | 2.1 | 5.6 | 0.4 | 3.0 | 6.1 | 9.2 | 11.5 | 1.6 | 23.1 | −11.8 |
| 35 to 44 | 100.0 | 104.8 | 36.2 | 2.9 | 19.5 | 1.1 | 3.7 | .3 | 6.0 | 8.6 | 12.7 | 17.6 | 5.3 | 10.4 | −4.7 |
| 45 to 54 | 100.0 | 103.6 | 36.4 | 2.8 | 23.2 | 1.3 | 4.4 | .6 | 9.2 | 8.2 | 18.6 | 8.6 | 5.2 | 8.3 | −3.5 |
| 55 to 64 | 100.0 | 101.5 | 29.1 | 2.3 | 34.0 | 1.5 | 5.7 | .6 | 12.6 | 14.2 | 15.4 | 9.0 | 4.2 | 6.9 | −1.5 |
| 65 to 69 | 100.0 | 101.0 | 31.8 | 2.7 | 33.0 | 1.8 | 8.0 | .6 | 12.4 | 10.8 | 16.4 | 3.7 | 5.7 | 7.2 | −1.0 |
| 70 or over | 100.0 | 100.5 | 31.6 | 2.5 | 36.2 | 1.8 | 8.4 | .5 | 12.3 | 13.7 | 18.4 | .3 | 5.1 | 5.8 | −.4 |
| Percent of households owning a given asset: | | | | | | | | | | | | | | | |
| Under 35 | | | 42.9 | 60.9 | 92.5 | 86.4 | 72.2 | 20.6 | 5.3 | 11.8 | 6.1 | 9.0 | 1.4 | | 80.5 |
| 35 to 44 | | | 65.7 | 73.0 | 93.4 | 89.6 | 73.6 | 23.5 | 11.0 | 25.0 | 15.2 | 15.5 | 2.6 | | 82.6 |
| 45 to 54 | | | 70.9 | 77.9 | 92.0 | 89.4 | 76.7 | 25.4 | 17.9 | 26.2 | 21.0 | 11.8 | 4.2 | | 73.8 |
| 55 to 64 | | | 74.0 | 78.0 | 94.6 | 90.2 | 76.3 | 24.2 | 24.0 | 22.4 | 18.6 | 11.8 | 2.6 | | 61.4 |
| 65 to 69 | | | 68.5 | 66.5 | 93.6 | 90.4 | 69.1 | 19.9 | 28.8 | 23.1 | 14.0 | 4.9 | 2.4 | | 44.5 |
| 70 or over | | | 64.1 | 60.1 | 96.1 | 90.9 | 74.7 | 13.5 | 27.1 | 18.1 | 16.1 | 3.4 | 1.9 | | 34.4 |
| Average size of holding per household owning a given asset (dollars): | | | | | | | | | | | | | | | |
| Under 35 | 20,056 | 22,428 | 19,650 | 2,345 | 3,752 | 485 | 1,579 | 466 | 11,599 | 10,416 | 32,688 | 30,590 | 22,476 | 4,819 | 2,945 |
| 35 to 44 | 65,386 | 68,501 | 36,001 | 2,592 | 13,865 | 827 | 3,333 | 860 | 35,760 | 22,495 | 54,518 | 80,592 | 132,792 | 7,251 | 3,769 |
| 45 to 54 | 74,889 | 77,562 | 38,420 | 2,671 | 19,348 | 1,113 | 4,355 | 1,837 | 38,593 | 23,441 | 66,247 | 75,688 | 92,487 | 6,649 | 3,624 |
| 55 to 64 | 108,574 | 110,230 | 43,621 | 3,149 | 39,739 | 1,797 | 8,197 | 3,322 | 57,141 | 68.469 | 89,989 | 102,889 | 190,012 | 7,901 | 2,698 |
| 65 to 69 | 88,300 | 89,227 | 40,975 | 3,576 | 31,709 | 1,711 | 10,323 | 3,606 | 38,018 | 41,061 | 103,494 | 85,247 | 206,958 | 6,779 | 2,082 |
| 70 or over | 73,450 | 73,795 | 36,282 | 3,057 | 28,144 | 1,460 | 8,354 | 3,846 | 33,381 | 55,271 | 84,280 | 15,725 | 196,650 | 4,323 | 1,002 |

Source: 1979 ISDP Survey: Second and fifth waves.

Aging interrelates with wealth in various and sometimes contradictory ways. Income generally rises up until the middle years, then levels off and declines as retirement approaches. To the extent that income and wealth accumulation are related, the latter would be expected to follow a similar path. Life cycle considerations stimulate homeownership and acquisition of durables while families are forming and growing, but often result in movement into smaller, rental quarters when the children leave. Probably the major impact of age as it concerns asset formation is the cumulative opportunity for acquisition of wealth as life extends into the middle and upper years.

The net effect of these factors is exhibited in table 7 in the proportions possessing various assets and in the average holdings of the various age groups. For most individual categories, asset ownership rates rise rapidly after the early years, reaching a peak in middle or upper middle age, before dipping downward. The average size of holdings, however, clearly continues to rise until upper middle age before some element of dissaving sets in.

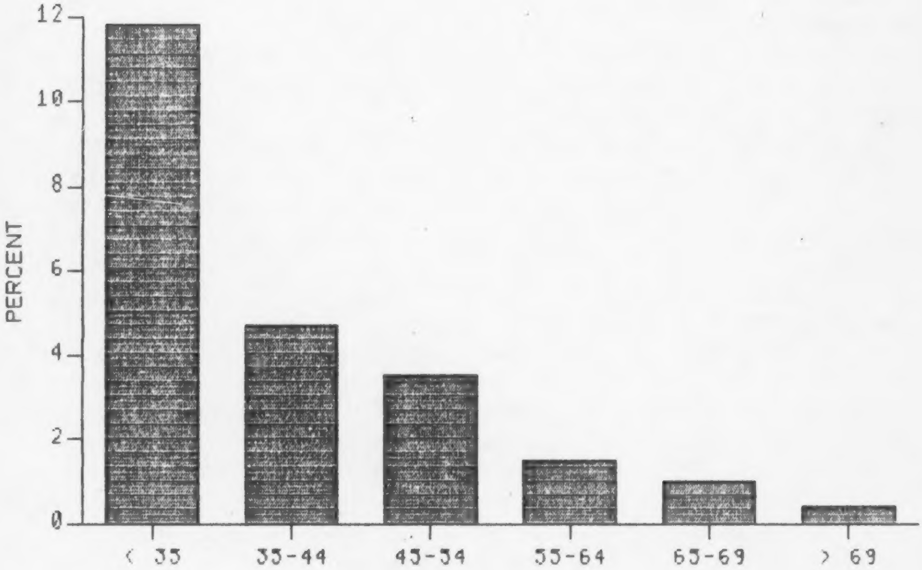
The distribution of holdings within age categories provides a somewhat different view of these tendencies. Among young households under 35 years of age, home equity is a rather dominant element in net worth, even though homeownership rates are well below average at that stage of life. The explanation for this apparent contradiction is that young families, in general, have little in the way of accumulated resources and those in a little stronger financial position have probably invested almost everything they have in their first homes, which are often condominium dwellings. The sizable percentage of the net worth of the young represented by automobile equity and household possessions reflects a similar circumstance. In fact, fully three-quarters of the wealth of young households is concentrated in these three tangible components. The relatively high ratio of debts to assets for the young can logically be attributed to their need for acquisition of possessions at this stage of life (chart 3).

With the gradual buildup of financial assets in the middle years, home equity drifts downward to a more typical level of about one-third of overall wealth. It is in these active years that equities in business and farm enterprises attain their greatest relative importance within the portfolio. Equity in rental property becomes more significant and remains so as age increases.

Home equity represents almost the same proportion of asset holdings among older households as among those in the middle years, in spite of the reduction in homeownership at those older ages. One reason is that older people remaining in their homes generally own them outright or have little mortgage indebtedness to offset their equity. The increase in condominium ownership, sometimes involuntary, has probably affected the elderly a good deal, as well as the young.

CHART 3

UNSECURED DEBT AS A PERCENT OF TOTAL WEALTH
BY AGE GROUP

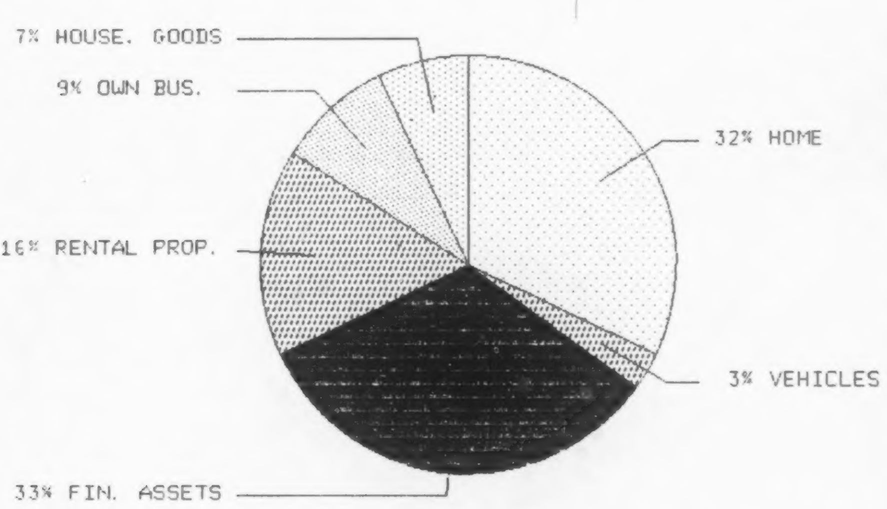


SOURCE: PEARL, ROBERT B. AND MATILDA FRANKEL. COMPOSITION OF THE AMERICAN HOUSEHOLDS AT THE START OF THE EIGHTIES. PAPER PRESENTED AT THE AMERICAN STATISTICAL ASSOCIATION, 1982.

The most striking difference for older households is the very large proportion (a third or more) of their net worth which is invested in financial assets (chart 4). Moreover, a much larger proportion of the resource of older people is concentrated in costly and less liquid categories (certificates of deposit, corporate stocks and bonds, etc.) than is the case for younger households. The low ratio of debts to assets for the elderly mirrors the diminution of their need to acquire possessions. In addition, medicare and medicaid could be playing an important role in keeping the elderly out of debt in spite of rising medical expenses.

CHART 4

WEALTH DISTRIBUTION OF HOUSEHOLDS
65-69 YEARS OF AGE



SOURCE: PEARL, ROBERT B. AND MATILDA FRANKEL. COMPOSITION OF THE PERSONAL WEALTH OF HOUSEHOLDS AT THE START OF THE EIGHTIES. PAPER PRESENTED AT THE AMERICAN STATISTICAL ASSOCIATION, CINCINNATI, OHIO, AUGUST 1982.

## 2. INCOME OF THE ELDERLY FROM ASSETS

Two other Social Security Administration studies published in 1983 [6] [7] shed light on a different set of questions: How many elderly people derive income from assets, and how large is that income? Based on the Census Bureau's Current Population Survey, two-thirds of the aged population in 1980 received asset income, including interest from savings accounts and bonds, dividends from stock, rental income, royalties, and income from estates and trusts.

The proportions of elderly units reporting receipt of asset income were several percentage points higher in 1980 than in 1978. However, income from assets has been the least well reported source of income in the Census Bureau's Current Population Survey. Total amounts of dividend income, for example, derived from the Current Population Survey, equal only 38 percent of total amounts of dividend income estimated from other sources. The increase in the elderly's reported receipt of income from assets in 1980 may be a reflection of better reporting of such income in response to a revised questionnaire. On the other hand, the proportion of aged reporting receipt of income from assets has increased from 49 percent in 1971, to 56 percent in 1976, 62 percent in 1978, and 66 percent in 1980, which suggests a trend toward increasing receipt of income from assets among the aged during the 1970's (chart 5).

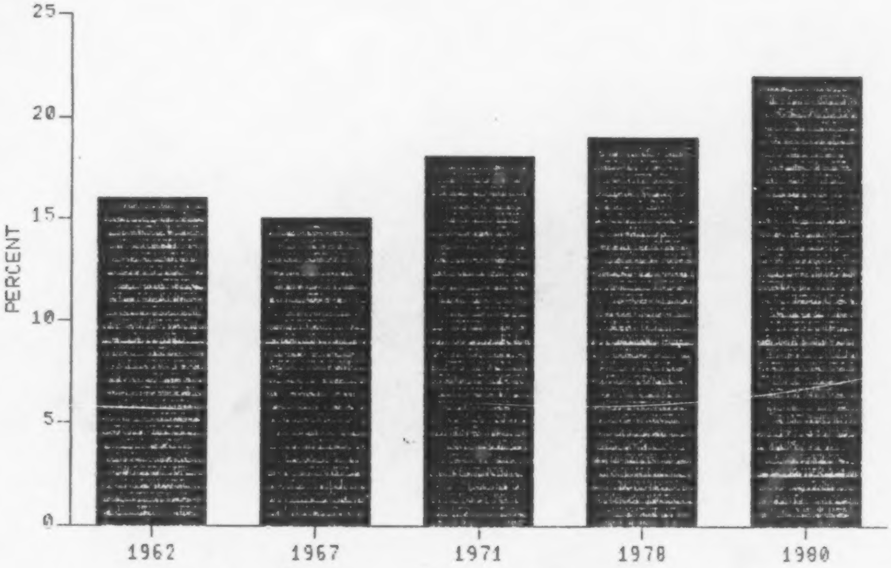
---

[6] Grad, Susan. Income of the Population 55 and Over, 1980. Social Security Administration. Office of Research and Statistics, 1983. Forthcoming.

[7] Upp, Melinda. Relative Importance of Various Income Sources of the Aged, 1980. Social Security Bulletin, January 1983, pp. 3-10.

CHART 5

ASSET INCOME:
PERCENT SHARE OF AGGREGATE INCOME OF THE ELDERLY



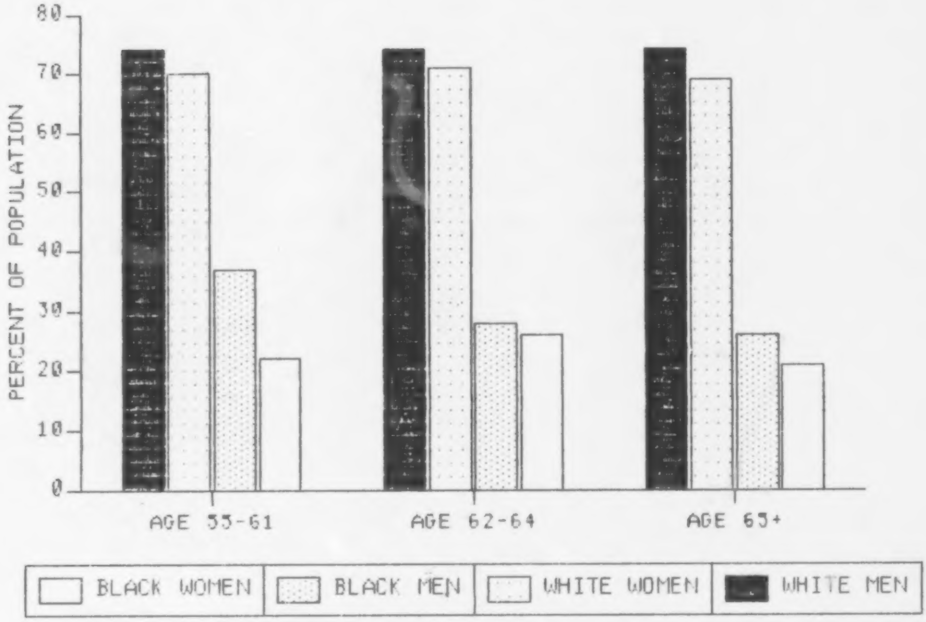
SOURCE: SOCIAL SECURITY BULLETIN, JANUARY 1983/Vol. 46, No. 1

The actual percentages of older men and women who received asset income in 1980 are shown in chart 6.

Three points need to be stressed from this data. First, the percentage of older people with asset income in 1980 remained relatively consistent across age groups, i.e., those between 55 and 61 had relatively the same percentage of asset income as those age 65 and over.

CHART 6

PERCENT OF AGED WITH ASSET INCOME BY AGE GROUP-1980



SOURCE: U.S. SOCIAL SECURITY ADMINISTRATION

Second, the distribution of asset income is very uneven. Older men have a substantially larger likelihood of receiving asset income than women, and substantially fewer black Americans report asset income than whites.

Third, 31 to 34 percent of the aged reported having no asset income whatsoever in 1980. And of those who did report asset income in that year, the annual median income reported was relatively low, i.e., half of the over-65 group with asset income had annual income above $1,140 a year, and half had asset income less than $1,140. Thirty-five percent of the units age 65 and over with asset income received less than $500 a year, while 20 percent had $5,000 or more in annual income from assets.

### 3. Relative Importance of Asset Income for the Elderly

Historically, income from savings and other assets has furnished a relatively small but growing portion of the income of the elderly. In 1980, for example, 22 percent of the total money income of the elderly came from asset income—compared to 15 to 16 percent in the 1960's.

Assets are an increasingly common source of income for the elderly, and, as we have seen, the share of total income provided by assets has also increased. At all income levels, income from assets is far more important than income from private pensions; in 1980, assets provided three times as much of the total retirement income of aged units as did either private- or government-employees pensions.

But asset income is a much more important source of income for higher income individuals than for those with lower income, as the following table illustrates. Whereas only 38 percent of those aged units with income less than $5,000 had some asset income, nearly all (97 percent) of those with incomes of $20,000 or more had some asset income. And while roughly one-fourth (27 percent) of the $20,000-and-over aged group relied on assets for more than half of their total income, only 2 percent of aged units with incomes of less than $5,000 derived half or more of their income from assets. Indeed, assets provided only 4 percent of the total money income of the low-income group, compared to 34 percent of total money income among the higher income aged units.[8]

TABLE 8.—ASSET INCOME DISTRIBUTION AMONG AGED UNITS, 1980

| Item | All units | Level of total money income | | | |
|---|---|---|---|---|---|
| | | Less than $5,000 | $5,000–$9,999 | $10,000–$19,999 | $20,000 or more |
| Percent of units with asset income | 66 | 38 | 72 | 89 | 97 |
| Percent of all units relying on assets for 50 percent or more of total income | 9 | 2 | 6 | 14 | 27 |
| Percent of units with assets and relying on assets for 50 percent or more of total income | 13 | 6 | 8 | 16 | 28 |
| Share of aggregate income provided by assets | 22 | 4 | 14 | 21 | 34 |

Source: Social Security Bulletin, January 1983.

In view of these findings about the overall level of assets and their uneven distribution among the elderly, virtually all of the expert groups and national commissions that recently studied retirement income have recommended the need for public policy to strengthen individual savings for retirement. Because historical savings rates of after-tax income have been relatively low, emphasis has been placed on tax incentives to encourage savings in the form of voluntary tax-deferred capital accumulation mechanisms.

## D. RECOMMENDATIONS OF ADVISORY GROUPS

### 1. President's Commission on Pension Policy

In its final report released in February 1981 the President's Commission on Pension Policy recommended the following steps to strengthen individual savings:

> Favorable tax treatment should be extended to employee contributions to pension plans. A refundable tax credit for low- and moderate-income people to encourage voluntary individual retirement savings and employee contributions to plans are recommended. At the time of tax filing, the employee would choose the higher of a tax deduction or a tax credit.

---

[8] These figures, and the table, are drawn from: Upp, Melinda. Relative Importance of Various Income Sources of the Aged, p. 8.

### 2. NATIONAL COMMISSION ON SOCIAL SECURITY

In its final report issued in March 1981, the National Commission on Social Security agreed that it should be the policy of the Federal Government to encourage individual saving for retirement.

> Again, the Commission regards private savings as an important part of the total income security of American families; it recommends a strengthening of the present individual retirement account (IRA) opportunities. Present law permits a maximum tax deductible contribution of $1,500 per year to a qualifying individual retirement account. The Commission believes this amount should be increased as a way to encourage savings.

### 3. COMMITTEE FOR ECONOMIC DEVELOPMENT

In September 1981, the Committee for Economic Development—an independent, nonprofit, research, and educational organization of 200 business executives and educators—issued a report called "Reforming Retirement Policies." In it, the CED recommended the following strategy for increasing personal savings:

> It is in society's interest to make increased individual savings for retirement a financially attractive and accessible goal. But changes in the tax law are necessary before a substantial number of current workers will be able and willing to increase their saving to any significant degree. Tax proposals to encourage saving generally deserve favorable consideration because they will reduce the current consumption bias in the Tax Code and contribute to a higher level of investment. Tax policies that directly encourage saving for retirement deserve the most emphasis of all. Accordingly, we give top priority in this area to the recommendation that persons covered by qualified pension plans be permitted to make tax-deferred contributions to either an IRA, a Keogh plan, or to a qualified pension plan.

## E. TAX INCENTIVES FOR CAPITAL ACCUMULATION

The Economic Recovery Tax Act (ERTA) of 1981 (Public Law 97-34) contained a number of important provisions designed to stimulate personal savings. In August 1981, the Special Committee on Aging published an information paper called "1981 Federal Income Tax Legislation: How It Affects Older Americans and Those Planning for Retirement." [9] The overall, 3-year, across-the-board reduction in tax rates have lowered the marginal tax on each additional dollar of income earned and will therefore make saving more attractive because the after-tax return on each dollar saved is increased.

In addition to the reductions in tax rates, the 1981 tax law contained specific incentives to increase savings, such as the provision exempting the so-called "all savers certificate" from Federal (and many States) income taxes and the provisions providing for special reductions in the tax on interest income (effective 1985) and on stock dividends of public utilities (effective 1982–85). But the most important savings provisions of the ERTA, from the standpoint of individual retirement income, were the provisions expanding tax-sheltered contributions to IRA and Keogh accounts which became effective in 1982 and the intended expansion of employee stock ownership plans.

---

[9] The Special Committee on Aging published, in addition, Protecting Older Americans Against Overpayment of Federal Income Taxes, December 1982.

### 1. Individual Retirement Arrangements (IRA's)

The Employee Retirement Income Security Act of 1974 (ERISA) contained provisions (section 2002) enabling individuals to set up individual retirement arrangements (IRA's) to save for retirement. Very simply, if an IRA is created, money paid into the plan is deductible for Federal income tax purposes, and the earnings on the money paid into the plan are tax deferred. The funds set aside and the earnings therefrom are not taxed until they are distributed to the individual. Under current rules, distributions cannot be made before age 59½ or delayed beyond age 70½ without incurring penalties. Thus, distributions normally begin after retirement, when the individual is usually in a substantially lower tax bracket.

The idea of providing tax incentives to encourage individuals to save for their own retirement can be traced to a message to the Congress from President Nixon in 1971. It was pointed out that many individuals were not covered by private pension plans, on the one hand, nor furnished tax incentives to save for their own retirement as were then available for the self-employed. To fill that gap, the President recommended that employees who wish to save independently for their retirement or to supplement employer-financed pensions should be allowed to deduct for tax purposes amounts set aside for retirement.

The President proposed in 1971 that contributions to retirement savings programs by individuals be tax deductible up to the level of $1,500 per year or 20 percent of income, whichever was less. This proposed deduction would have been available to those already covered by employer-financed plans, but in this case, the upper limit of $1,500 would have been reduced to reflect pension plan contributions made by the employer.

Congress appreciated the complexities involved in determining the exact amount of money that an employer contributed on behalf of each individual in a defined benefit pension plan. It was also concerned with the revenue losses that such a program would cause and the newness of the program itself. Therefore, in passing the ERISA legislation in 1974, Congress limited the tax incentives to individuals not covered by an employer-sponsored pension program since they generally would be more in need of supplemental retirement income. These individuals were permitted to contribute to an individual retirement arrangement (IRA), the lesser of 15 percent of compensation or $1,500. The assets of an IRA could be invested in a trusteed or custodial account with a bank, savings and loan, or credit union, in mutual funds, or in an annuity contract issued by an insurance company. This deduction for retirement savings was effective for taxable years beginning after December 31, 1974. Basically, the IRA provisions, as outlined above, remained the same until the recent changes in the Economic Recovery Tax Act became effective January 1, 1982.

### (A) IRA'S AND THE ECONOMIC RECOVERY TAX ACT OF 1981 (ERTA)

In 1981, Congress heeded the recommendations of the various advisory groups about the need to strengthen personal savings for retirement income and made major changes in the IRA provisions, both expanding the amounts that can be contributed to IRA's and expanding the eligibility for IRA's far beyond the eligibility rules laid down in 1974. (To help answer consumer questions, the Special Committee on Aging published "A Guide to Individual Retirement Accounts," in December 1981.)

> Specifically, the Senate Finance Committee gave the following reasons in support of the 1981 changes:[10]
>
> The committee is concerned that the resources available to individuals who retire are often not adequate to avoid a substantial decrease from preretirement living standards. The committee believes that retirement savings by individuals can make an important contribution toward maintaining preretirement living standards and that the present level of individual savings is too often inadequate for this purpose. The committee understands that personal savings of individuals have recently declined in relation to personal disposable income (i.e., personal income after personal tax payments). During the years 1973 through 1975, the personal savings rate was no more than 8.6 percent. It declined to 5.2 percent in 1978 and 1979, and rose only slightly in 1980 to 5.6 percent. (These savings estimates include employer payments to private pension funds.)
>
> The committee has found that the present rules providing tax-favored treatment for individual retirement savings have become too restrictive in view of recent rates of inflation and because they do not sufficiently promote individual savings by employees who participate in employer-sponsored plans.
>
> The committee bill is designed to promote greater retirement security by increasing the amount which individuals can set aside for retirement in an IRA, and by extending IRA eligibility to individuals who participate in employer-sponsored plans. The bill also extends additional tax-favored treatment to voluntary employee contributions to employer-sponsored plans so that plan participants can take advantage of systematic payroll deductions to accumulate tax-favored retirement savings.

Before the new tax law, deductions to an individual retirement account (IRA) were limited to the lesser of 15 percent of compensation or $1,500. Under the new law, for taxable years after December 31, 1981, the limit on contributions is the lesser of 100 percent of compensation or $2,000.

---

[10] U.S. Congress. Senate. Committee on Finance. Report No. 97-144.

Further, the new law allows workers covered by a company pension plan to participate in IRA accounts. Such workers were excluded from IRA's until 1981. For taxable years after December 31, 1981, the $2,000 limit on contributions will apply to contributions the employee may make to an IRA or as a voluntary contribution to the company plan. Such voluntary contributions and earnings from the voluntary contributions will generally be subject to IRA-type rules. Note that mandatory employee contributions to a company plan are not tax deductible, under the new law, although various experts have testified at congressional hearings that it would be a good idea to make mandatory employee contributions also deductible. In 1981, such plans were not made deductible because: (1) The revenue loss would have been substantial, and (2) it was felt that making mandatory contributions tax deductible would not have as much of an effect in creating new savings as would the deductibility of voluntary contributions.

### (B) IRA'S FOR NONEMPLOYED SPOUSES

The pre-ERTA IRA provisions allowed a worker to set up an IRA for a nonemployed spouse. The maximum combined contribution allowed under prior law was $1,750, and the contributions had to be in equal amounts for each spouse. As a result of the new tax law, the limit on contributions to a spousal IRA, after December 31, 1981, is $2,250 instead of $1,750. Also, the new law deletes the previous requirement that contributions under a spousal IRA be equally divided between the spouses. The new law has no such rules, except that no more than $2,000 can be contributed to the account of either spouse.

Prior law forbade the nonearning spouse from making contributions to a spousal IRA after a divorce. Without wage or salary income, that individual could not continue making contributions to his or her one-half share of a spousal IRA.

The new law, effective January 1, 1982, allows a divorced spouse to continue making contributions to a spousal IRA under certain conditions. The individual's former spouse must have established the spousal IRA at least 5 years before the divorce, and the former spouse must have contributed to the spousal IRA for at least 3 of the 5 years preceding the divorce. If those requirements are met, then the divorced spouse may continue to make contributions to the spousal IRA up to a maximum of the lesser of $1,125, or the divorced spouse's total compensation and alimony includable in gross income.

### (C) EMPLOYER-SPONSORED IRA'S OR SIMPLIFIED EMPLOYEE PENSIONS

The Revenue Act of 1978 (Public Law 95-600) provided for an increased deduction for contributions to an employee's individual retirement plan by the employer under an employer-sponsored IRA called a simplified employee pension.

If an individual retirement account or individual retirement annuity (IRA) qualifies as a simplified employee pension (SEP), both the employee and the employer may make contributions to the employee's IRA. Before the Economic Recovery Tax Act of 1981, employer contributions for an employee under a SEP were includable in the gross income of the employee and the employee was allowed a deduction for the employer contribution, limited to the lesser of 15 percent of compensation or $7,500. With respect to employee contributions, the limit was $1,500 (or 15 percent of compensation, if less) reduced by the amount of deductible employer contributions for that year.

The ERTA raised the limit on employee contributions to $2,000, and raised the ceiling on employer contributions from 15 percent or $7,500, to 15 percent of compensation or $15,000, whichever is lower, effective January 1, 1982.

TABLE 9.—ASSETS OUTSTANDING IN INDIVIDUAL RETIREMENT ACCOUNTS, 1981–83

[In billions]

| Financial institution | Dec. 31, 1981 | Apr. 30, 1982 | Dec. 31, 1982 | Apr. 27, 1983 |
|---|---|---|---|---|
| Commercial banks [1] | $7.0 | $12.6 | $17.9 | $26.3 |
| Thrift institutions [1] | 12.6 | 22.5 | 27.7 | 33.6 |
| Mutual funds: | | | | |
| Money market [1] | 1.5 | 3.4 | 4.6 | 5.3 |
| Equity | 1.1 | 1.5 | 2.8 | [2] 4.0 |
| Credit unions | .2 | .5 | NA | NA |
| Life insurance | 3.3 | NA | [3] 6.0 | [4] 10.3 |
| Total holdings [5] | 25.7 | 43.8 | 59.5 | 80.0 |

[1] IRA and Keogh accounts

[2] March 1983 data.

[3] September 1982 data.

[4] March 1983 preliminary data.

[5] Totals computed using latest available data for each sector.

Sources: EBRI tabulations of data provided by Federal Reserve Board, National Creidt Union Administration, Investment Company Institute, and American Council of Life Insurance.

## 2. KEOGH ACCOUNTS

As tax-qualified pension plans spread, many small business people found that their employees could benefit by being included in tax-qualified pension plans, but the employers could not. Nor could self-employed individuals without employees. Further, where two people operated similar businesses and realized similar profits, but if one was a sole proprietor and the other was incorporated, the corporate operator could benefit from a pension plan even though he was the only employee of the corporation, but the sole proprietor could not.

Efforts were made to remedy this situation, and various bills were introduced in Congress. The number H.R. 10 was assigned to an early bill and was retained in succeeding bills until enactment of the Self-Employed Individuals Tax Retirement Act of 1962. Today these retirement plans are commonly known as H.R. 10 plans or Keogh plans (named for Representative Eugene J. Keogh of New York who sponsored the legislation).

The purpose of the Self-Employed Individuals Tax Retirement Act of 1962 was to enable self-employed individuals to participate in a tax-qualified retirement plan if they chose to do so, in much the same way as employees could. Various restrictions and limitations, however, were included in this 1962 legislation.

Contributions on behalf of owner-employees were permitted to the lesser of 10 percent of earned income or $2,500—but the allowable tax deduction for any self-employed individual (whether an owner-employee or not) was limited to one-half of the contribution, up to a maximum of $1,250 in a taxable year. The provision reducing the allowable deduction to one-half of the contribution was repealed by Public Law 89-909, effective for taxable years beginning after December 31, 1967. ERISA made additional liberalizations in 1974.

Prior to ERISA's passage in 1974, self-employed people who established a Keogh plan were limited to a contribution of $2,500 per year, while there was no limit imposed on corporate plans. It was found that this led to otherwise unnecessary incorporation by self-employed persons solely for the purpose of obtaining the tax benefits for retirement savings. To achieve greater equity vis-a-vis corporate plans, Congress, in passing ERISA, increased the annual limit for deductible contributions to Keogh plans to 15 percent of earned income or $7,500, whichever was lower, and it also provided a new minimum deduction based on the lesser of 100 percent of earned income or $750. An overall limit of $100,000, however, was set on earned income that could be taken into account under a plan that includes self-employed individuals.

In general, under a tax-qualified plan, loans to participants are permitted if certain requirements are met. However, H.R. 10 or Keogh plans were not permitted to lend to an owner-employee. If an owner-employee participating in an H.R. 10 plan borrowed from the plan, or used an interest in the plan as security for a loan, the amount of the loan or security interest was treated as a plan distribution, and the usual tax rules for distributions applied.

### (A) 1981 TAX LAW CHANGES IN KEOGH ACCOUNTS

In 1981, Congress reviewed the Keogh provisions at the same time that it expanded eligibility for IRA's and decided there were reasons for a change, as stated in the Senate Finance Committee Report No. 97-144:

> The maximum deductible contribution for H.R. 10 plans has not been revised since 1974. The committee believes this limit should be increased as an adjustment for inflation and to make these plans more attractive.
>
> The committee also believes that current provisions permitting partners who are not owner-employees to borrow against their interest in an H.R. 10 plan diminish retirement savings. Accordingly, to promote long-term savings for retirement, the committee believes the current treatment of loans and pledges should be applied to all partners.

The 1981 law retained the present limit of 15 percent of compensation as under prior law, but effective with taxable years after December 31, 1981, it increased the maximum deduction for employer contributions to a defined contribution Keogh plan, to a defined contribution plan maintained by a subchapter S corporation, or to a simplified employee pension (SEP). The maximum deduction was increased from $7,500 to $15,000.

To provide a similar increase in the level of benefits permitted under a defined benefit Keogh or subchapter S corporation plan, the compensation taken into account in determining the permitted annual benefit accruals was increased from $50,000 to $100,000.

### (B) 1982 TAX LAW CHANGES IN KEOGH ACCOUNTS

As part of the Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248), Congress made significant changes in the tax provisions affecting employee benefit plans. TEFRA establishes parity between corporate and noncorporate plans. To this end, most of the special rules applicable to Keogh plans have been removed for tax years beginning after 1983.

Maximum limits have been increased effective in 1984 in line with the new $90,000/$30,000 limits for corporate plans. This represents at least a twofold increase in the benefits and contributions for Keogh plans. New loan rules apply to Keogh as well as to non-Keogh plans. Keogh plans will be subject to the same top-heavy rules as other plans. A top-heavy plan is defined as a plan under which more than 60 percent of the accrued benefits (or contributions) are provided for key employees. A key employee is defined as an officer, a 5-percent owner, a 1-percent owner with compensation in excess of $150,000 or the employees owning the 10 largest interests in the employer.

Special requirements for top-heavy plans include accelerated vesting schedules and a minimum benefit. Full vesting would be required after 3 years service, or, alternatively, graded vesting beginning with 20 percent after 2 years service increasing by 20 percent each year so that 100 percent vesting is attained at the end of 6 years of service. The minimum benefit required of a top-heavy plan would be 2 percent of pay multiplied by the employee's years of service (not to exceed 20 percent) in a defined benefit plan. A contribution of 3 percent of pay would be required in a defined contribution plan, or if less, the highest contribution rate for any key employee.

The effect of removing the special Keogh restrictions is:

Benefits no longer have to be immediately vested.

Social security integration rules have been eased.

Assets do not have to be held by a bank or financial institution.

The limitations on benefits provided to owner-employees are removed.

Past service benefits can be provided under a defined benefit Keogh plan as in corporate plans.

Keogh plans can limit employee coverage under the same rules used by corporate plans.

Owner-employees do not have to give their consent to participate.

The 6-percent excise tax on excess contributions no longer applies.

Voluntary contributions up to 10 percent of compensation will be allowed even where only owner-employees participate.

There no longer is a 5-year restriction on participating again in the plan for an employee who receives a premature distribution.

In addition, the first $5,000 of a lump-sum death benefit paid under a Keogh plan for deaths occurring after December 31, 1983, will be eligible to be excluded from Federal income tax.

The Senate Finance Committee gave the following reasons for making the change:

> The committee recognizes the importance of tax incentives in creating a strong pension system. At the same time, however, the committee believes it is necessary to provide more appropriate limitations to prevent excessive accumulations of tax-sheltered funds. Moreover, by reducing limitations on corporate plans, and increasing the deduction limits for [H.R.] 10 [or Keogh] plans, the bill takes a significant step toward equalizing the treatment of plans benefiting only common law employees and plans for the self-employed.[11]

The combined effect, therefore, of treating Keogh plans and corporate plans under the same pension rules is to increase the pension incentives under Keogh or H.R. 10 plans and also to eliminate the tendency for professionals to incorporate simply in order to take advantage of the higher amounts that could be sheltered from paying taxes under prior law.

### 3. Employee Stock Ownership Plans

Since 1974, Congress has by legislation created several new programs designed to give employees the chance to acquire a stock ownership interest in their employer. Under ERISA, Congress first defined the employee stock ownership plan, or "ESOP." In the Tax Reduction Act of 1975, and the Tax Reform Act of 1976, Congress implemented and then expanded a variation on the original ESOP, the tax credit employee stock ownership plan (TRASOP). Finally, in the Economic Recovery Tax Act of 1981, TRASOP's were replaced with another variation, the payroll-based tax credit employee stock ownership plan, the so-called "PAYSOP." About 4,000 ESOP's have been created since the passage of ERISA 10 years ago.

ESOP's provide employees the opportunity to acquire ownership of stock, generally without having to spend any personal income. Although some ESOP's permit or require employee contributions, most provide that the employer will make all necessary payments. ESOP's are tax-qualified employee benefit plans, and are therefore required to be operated for the "exclusive benefit" of participating employees and their beneficiaries.

The employer stock is acquired and held for the benefit of employees. The stock, which is held by a tax-exempt trust under the plan, may be acquired through direct employer contributions of stock or by using moneys borrowed by the trust. Under the usual rules applicable to tax-qualified plans, an employee's benefits under an ESOP are generally not taxed until they are distributed or made available.

---

[11] U.S. Congress. Senate. Committee on Finance. Tax Equity and Fiscal Responsibility Act of 1982. Report of the Committee on Finance on H.R. 4961 together with Additional Supplemental and Minority Views. Senate Report 97-494, 97th Cong., 2d Sess., July 12, 1982. Washington, U.S. Govt. Print. Off., 1982, v. I, p. 314.

Most conventional ESOP plans came about as the employer contributed company stock to the trust. But a smaller number of ESOP's are leveraged, i.e., to acquire stock of an employer for the benefit of employees, and ESOP may borrow money from a bank or other lender. The stock is then bought directly from the employer or from shareholders. When the ESOP borrows the money to purchase the stock, the employer guarantees to the lender that the ESOP will repay the loan.

Employees are never required to assume any obligation for the repayment of the money borrowed by the ESOP. The employer is required to make annual payments to the ESOP in an amount at least equal to the amount the ESOP must pay on the money it borrowed. These amounts are then paid by the ESOP to the lender each year. The employer is also permitted to make additional payments of cash or stock to the ESOP each year.

The employer gets a tax deduction for all payments to the ESOP, up to a maximum limitation established by the Internal Revenue Code. This tax deduction is available for the required employer payments to service the loan and any additional payments, and the tax effect is to reduce the annual cost of the ESOP to the employer. Cash put into the ESOP by the employer will be used primarily to purchase employer stock. In addition, this cash may be invested temporarily in savings accounts or certain other permitted investments.

TRASOP's can be found primarily in large, capital-intensive industries. Their purpose is the same as an ESOP, but their funding is different. Until they were replaced by PAYSOP's, TRASOP's were funded with money the employer would otherwise have paid in taxes by taking an investment tax credit against its annual tax liability. TRASOP "contributions" were directly related to a company's qualified capital investments, so that a rise or fall in the amount invested, reflected in the investment tax credit, would increase or decrease the TRASOP "contribution."

Given congressional support for the ESOP concept, Congress reviewed the plans during the consideration of the Economic Recovery Tax Act of 1981, and found reasons to make changes. Specifically, the Senate Finance Committee Report 97-144 listed the following reasons for change:

> The committee believes that experience in the operation of the tax laws applicable to employee stock ownership plans indicates that several changes are appropriate. The committee is concerned that the investment-based tax credit for ESOP's has not provided a sufficient incentive for the establishment of ESOP's by labor-intensive corporations. The committee believes that a permanent payroll-based tax credit for employer contributions to a tax credit ESOP will provide a more effective incentive than the additional investment tax credit currently allowed. In addition, the rules in present law which limit the ability of a leveraged ESOP to acquire employer securities with the

> proceeds of a loan to the plan have proved too restrictive and have prevented the use of leveraged ESOP's as a technique of corporate finance. Certain of the provisions governing distributions to participants under a tax credit ESOP or leveraged ESOP have proved burdensome and, in some cases, have precluded an employer from establishing an employee stock ownership plan.

The Economic Recovery Tax Act of 1981 terminated, after 1982, the investment-based tax credit for ESOP, and replaced it with a payroll-based tax credit. The payroll-based credit is allowed for wages paid in calendar years 1983 through 1987. For calendar years 1983 and 1984, the credit is limited to 0.5 percent of compensation paid to employees under the plan, and to 0.75 percent of such compensation for 1985, 1986, and 1987. The provision expires January 1, 1988. Although this provision will not have any direct effect on taxes paid by individuals, the change from an investment tax credit to a payroll-based credit is intended to encourage the spread of ESOP plans among labor-intensive firms, which have derived little tax benefit in the past from the investment-based credit.

The new law increases the limit on ESOP deductions from 15 percent of aggregate employee compensation, to 25 percent of compensation where the contributions are applied by the plan to make principal payments on a loan incurred to purchase employer stock. An unlimited deduction is allowed for employer contributions applied to pay interest on the loan. The new law also removes contributions to pay loan interest and forfeitures of fully leveraged ESOP stock from the limit on contributions to any participant's account, provided the contributions to officers, shareholders, and employees whose compensation exceeds $83,000 do not exceed specified limits.

## 4. Current Issues and Legislation in 1983

### (A) CONTINUED GROWTH OF INDIVIDUAL RETIREMENT ARRANGEMENTS

Contributions to, and assets held by IRA's increased dramatically during 1983 in response to ERTA's expansion of IRA eligibility, according to data compiled by the Employee Benefit Research Institute (EBRI). Between January and the end of April 1983 alone, IRA deposits increased by $20.5 billion, bringing total IRA deductions on 1982 tax returns to $54.3 billion. This compares to the $25.7 billion held in IRA accounts at the end of 1981, an amount accumulated over the entire 1975–81 period. IRA deposits are tax-deferrred, not tax-exempt, but they can still have a dramatic impact on current Federal revenues. The final conference committee report on ERTA projected Federal revenue losses due to ERTA-generated IRA deposits to be $0.98 billion in 1982 and $1.345 billion in 1983. Based on actual contributions for tax year 1982, EBRI estimates that Federal revenue losses will be closer to $15.2 billion for 1982 and $14.6 billion for 1983.

These figures suggest that the sudden growth in IRA deductions will become an important policy issue in the coming year. IRA's constitute a major short-term revenue loss for the Federal Government. Federal tax expenditures on IRA's may now be as much as one-third the size of the tax revenue loss attributable to tax expenditures on public and private employer pension plans, estimated in the fiscal year 1984 budget to be $45.3 billion for 1982 and $49.7 billion for 1983.[12]

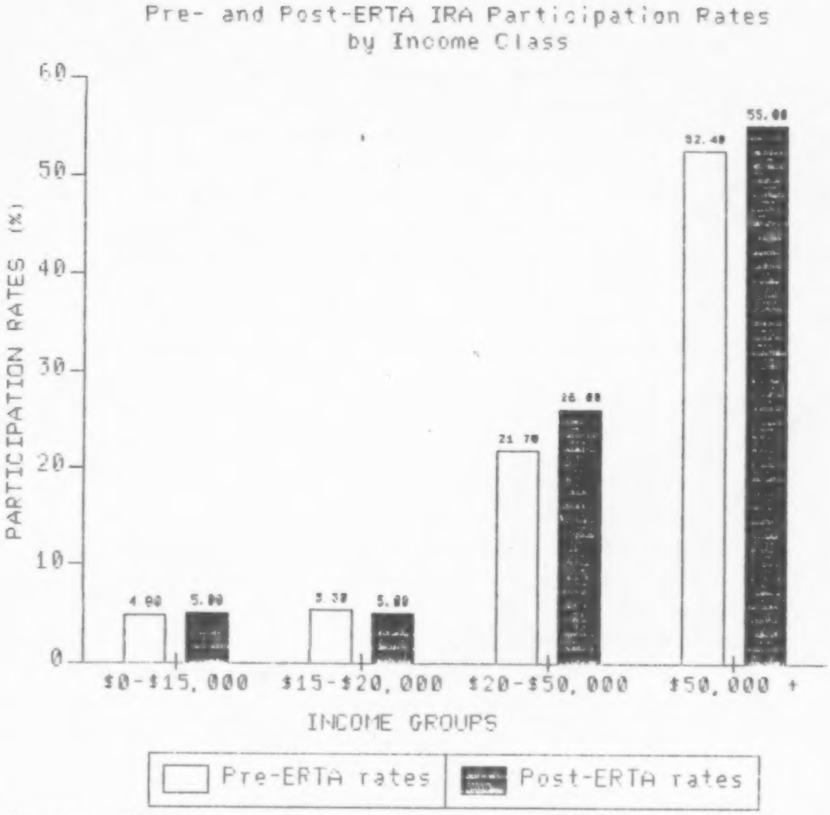
The rapid growth of IRA's poses dilemmas for employers as well as Federal retirement income policy. As IRA's come to play an increasingly more important role in the retirement planning of employees, they may diminish the importance of the pension bond which links the interests of employers and employees. Employers may indeed face new problems in trying to control the composition of their work forces. Employers design pension plans in a manner that permits them to control, to some degree, when their employees will retire. The increased availability of IRA's, and the growing reliance of employees on them, reduces the incentive of employee's to participate in employer-sponsored defined contribution plans.

The size of current IRA deposits, coupled with the distribution of taxpayer participation by income level for IRA's, raises serious public policy concerns. Participation among low-wage taxpayers is quite low for IRA's; they are utilized primarily by middle to upper income taxpayers. ERTA's expansion of the availability of IRA's may not have improved this distribution, but made it worse (see chart 7). Pensions, in contrast, must be offered to all employees on a nondiscriminatory basis, and this policy is enforced by antidiscrimination requirements in the Tax Code. While this policy does not distribute pension-related tax benefits evenly among all income groups, it assures that all income groups will have some opportunity to participate in the pension plan.

---

[12] Employee Benefit Research Institute. 1982 IRA Growth Sets New Record. 1983.

CHART 7



Source: EBRI Analysis of Treasury Department Data, June 1983

Despite this apparent inequitable distribution in the utilization of IRA tax deduction benefits, interest has continued to grow in the further liberalization of limits on contributions to IRA's and reduction of obstacles to early withdrawal of contributed assets. A proposal introduced by Representative Hance (H.R. 3661) would index contribution limits to offset the effects of inflation and obviate the need for ad hoc increases by Congress. A second bill, introduced by Representative Moore (H.R. 2000), would permit additional, nondeductible contributions to IRA's of $2,000 annually plus another $8,000 over the lifetime of the account. While these additional contributions would not be tax deductible, interest accruals would still be tax deferred until distributed from the account. The bill would also permit early withdrawals of up to $10,000 to pay for college tuition or to purchase a house.

Legislation has been introduced by Senator Roth (S. 128) and Senator Grassley (S. 214) to increase the contribution limits to spousal IRA's. The administration has also proposed an increase in the aggregate contribution limit for spousal IRA's from $2,250 to $4,000 in the fiscal year 1985 budget.

Those who oppose liberalizing IRA contribution limits contend that any increase would primarily be to the advantage of middle-

and upper-income taxpayers, since the small percentage of lower-income taxpayers who do utilize IRA's often do not contribute the full $2,000 deduction permitted them each year. Since these proposals would also decrease revenues, with the indexation of contribution levels presenting the greatest potential tax revenue loss, it is unlikely any of them will be enacted given congressional concern over the present Federal deficit.

### (B) CONTINUED PROMOTION OF EMPLOYEE STOCK OWNERSHIP PLANS

ESOP's, by their nature, can be used for many purposes in addition to giving employees an ownership interest in their employer's company. They can be used as a means of selling the firm to employees, converting a public concern into a privately held company, or as in the case of the recent formation of an ESOP by the Dan River Corp., a defensive weapon against an unfriendly takeover attempt by another corporation. The fact that an ESOP can be used for so many purposes increases the risk of a conflict in interest between employer and employees, however. It is therefore important that any such actions be undertaken with the foreknowledge of plan participants.

Although ESOP's can become a valuable source of retirement income to supplement basic social security and pension benefits, they are not designed—and were never intended—to be an employee's sole source of employer-provided retirement benefits or a replacement for defined benefit plans. The purpose of an ESOP is to give employees an ownership interest in their employer; to give them a voice in decisions affecting the way in which the company is run and to give them an incentive to increase their productivity.

ESOP's can offer employees potential investment returns exceeding those of traditional pensions if the company is growing at a substantial rate, but at a considerably increased risk. Employees not only bear the risk of the plan's investment performance, but also bear the additional risk of relying on an investment in only one stock. Because the value of the shares of company stock varies so greatly with the fortunes of the employer, an ESOP cannot be considered a secure primary retirement vehicle for employees. Thus there has been considerable concern over recent action by some corporations which have terminated their defined benefit pension plans and replaced them with ESOP's.

The most sensitive issue surrounding employee stock ownership plans is their expanded use in closely held corporations, where the value to employees of such plans is uncertain. For employees to have meaningful ownership interest in their employer through participation in an ESOP, the stock must be fairly valued and the employee must have some control over the way in which the stock is to be voted. But in a privately-held corporation, one or both of these requirements may be constrained.

In the past, ESOP growth among privately-owned corporations with high work force turnover has been discouraged because high turnover could result in such a wide dispersal of stock among former employees that a small or family-owned firm could effectively become publicly owned against the will or intent of those who formed it. Legislation introduced by Senators Dixon, Stevens, and Long (S. 748) is intended to encourage the growth of ESOP's in such corporations by limiting the voting rights passed through to employees. Critics of the legislation reply that limitations on voting rights compromise both the ownership and productivity incentives which form the basis of congressional policy favoring ESOP formation, without limiting employees' exposure to the increased risks inherent in ESOP participation.

It is very difficult to value stock contributed to the ESOP of a privately-owned corporation because there is no ready market for the resale of the stock. This difficulty creates an enormous potential for abuse. By overvaluing stock contributions, the employer can inflate its tax deduction for contributions to the plan, while employees are hurt because the real value of the stock in their ESOP account is less than its nominal worth.

S. 748 contains a requirement that any stock contributed to an ESOP under these circumstances be issued and outstanding at least 24 months before its acquisition by the ESOP. Critics argue that the efficacy of this safeguard is questionable, at best. The key to determining the value of any given stock is not how long it has been outstanding, but whether there is a ready market for its resale, and what its resale history has been. The market for employer stock under this proposal is no greater than if the stock were issued directly from the company's treasury.

Although Congress has expressed its intent to encourage employee stock ownership, the effectiveness of the ownership and productivity incentives which form the basis of congressional policy have been debated. In the case of ESOP's in closely held corporations with limited voting rights passthrough, as contemplated by S. 748, the absence of voting rights and a ready market for resale cast doubt on the existence of any realistic incentive at all. Even in publicly-traded corporations with full passthrough voting, some employee organizations have argued that stock in the ESOP does not accumulate fast enough, or in amounts large enough compared to the total amount of stock outstanding, to give employees as a group any significant voice in corporate decisionmaking. As a result, several employee organizations have opposed the implementation of ESOP's unless coupled to representation on the employer's board of directors.

The ESOP concept still appears to be viewed positively by Congress, in spite of these unresolved issues. By including an ESOP in the negotiated agreement to fortify the solvency of the Chrysler Corp. some years ago, Congress sanctioned the use of ESOP's as a mechanism for salvaging financially troubled firms or industries.

It is important to note, however, that since an ESOP's value is inextricably tied to the financial health of the employer, ESOP's should be traded off against current wages rather than retirement benefits when being used to save financially stressed employers. If the ESOP is used to replace pension benefits, the demise of the employer could wipe out a substantial portion of an employee's retirement income. But by exchanging the ESOP for current wages, an employee's retirement income is insulated to an increased degree from the consequences of an employer's possible business failure, and a much stronger link is forged between productivity incentives and the employee's present compensation. The interest of older workers near retirement differ greatly from those of younger workers, such that an ESOP cannot be utilized as a replacement for traditional pension benefits without having a differential effect on the interests of certain groups of employees.

## F. PROGNOSIS FOR SAVINGS AND ASSET ACCUMULATION

Predictions of future personal savings rates are especially tenuous because they depend on a very complex set of interrelated economic factors. Although Congress has attempted to encourage personal savings with new tax-favored devices like IRA's, it is not yet clear that they have brought about a significant increase in aggregate savings rates, especially at lower income levels. Some survey evidence exists suggesting that roughly one-third of IRA contributions represent savings that taxpayers otherwise would have spent. But the increased margin of savings must be weighed against the significant cost to the Federal Government of providing this tax-deferred savings mechanism. Looming budget deficits may increase pressures to find new ways to encourage personal savings, or discourage personal consumption, which do not represent such a significant drain on Federal revenues.

The growth of IRA assets has significant implications for the future provision of retirement income. IRA's will become an important income source for the elderly in the next century, according to a recently released EBRI study.[13] The report indicates that sustained long-term growth of IRA contributions will add substantially to retirement income security for much of the working population. For 62 percent of the worker group that is presently aged 25 to 44, IRA's will generate an estimated $2,600 to $2,700 in additional annual retirement income beginning at age 65. This group constitutes the majority of the current labor force.

Others have pointed out, however, that the IRA's will certainly not be attractive for low-income individuals, given the pattern of participation in the past, and the especially large tax value IRA's provide for upper income workers in the $20,000 to $50,000 range. So the debate about savings in public policy in the future will probably continue to consider whether it is appropriate to encourage savings by low-income workers through special tax measures: For example, in 1981, the President's Commission on Pension Policy recommended the use of the tax credit as opposed to a tax deduction.

Tax credits affect all taxpayers equally—dollar for dollar—rich or poor, since their value does not fluctuate depending on the taxpayer's marginal tax bracket. Tax credits are subtracted from a taxpayer's tax liability, whereas tax deductions are subtracted from gross income in determining taxable income before the tax is computed. The net result is that for each dollar of tax credit a taxpayer's tax liability is reduced $1. On the other hand, IRA deductions reduce a taxpayer's liability but only by the percentage of the deduction; the percentage is dependent on the marginal tax bracket of the taxpayer—the higher income people have a higher marginal tax bracket and thereby benefit relatively more on their taxes than lower income people.

---

[13] Schieber, Sylvester J. Social Security: Perspectives on Preserving the System. Washington, Employee Benefit Research Institute, 1982.

Without special incentives for low-income people, IRA's will increase the proportion of the elderly with asset income and increase the amount of that income but they won't contribute much to eliminating poverty among the elderly.

Future debate will also evaluate the advisability of making mandatory employee contributions to company plans tax deductible. This was considered but not accepted during consideration of the Economic Recovery Tax Act of 1981, largely because the revenue losses would have been substantial and the net increase in savings was not estimated to be as large. Nevertheless, this issue of tax deductible mandatory contributions will still be considered. It was proposed, for example, in S. 1541, the Retirement Income Incentives and Administration Simplification Act of 1981, and recommended by experts who testified on that bill before the Labor Subcommittee in November 1981, as well as by other groups testifying on social security before the Joint Economic Committee on September 22-23, 1981.

The ESOP concept is viewed positively by Congress, and the concept is often applauded by employees as a chance for a greater share in their company's fortune and hailed by employers as an innovative way of financing the company's expansion. If anything, one might anticipate greater improvements in the ESOP legislation and continued popularity with employers and employees in the years ahead. Nevertheless, because the value of the shares of company stock varies so dramatically with the fortunes of the company, it can never be expected that ESOP plans will provide the major portion of total retirement income, although they will undoubtedly play a growing role in supplementing social security and other employee benefits.

Important factors that could increase overall personal savings in the future include the broad reductions in individual tax rates and the indexing of the tax system in 1985 to prevent individuals from falling into higher tax brackets. The reductions in personal tax rates, and the indexing provisions in particular, are likely to be reevaluated by the 98th Congress in terms of their overall economic effects and their impact on Federal Budget deficits.

Because of the estimated changes in the population's age structure, however, analysis suggests there will be a gradual increase in personal savings over the next 40 to 45 years.[14] As the baby boom generation enters middle age in the 1980's, this demographic change should tend to increase savings because middle-aged people tend to save more. This positive demographic trend is projected to continue through the first quarter of the 21st century, but as the baby boom generation reaches advanced age toward the middle of the next century, total personal savings could decline, in relative terms, because of the lower savings flow of the large, over 65 group. Such forecasts, however, are based on savings surveys that are 10 to 20 years old. There also have been substantial policy changes since those surveys were conducted—namely the expansion of social security and private pensions of the elderly.

---

[14] Wachtel, Paul. The Impact of Demographic Changes On Household Savings, 1950-2050. President's Commission on Pension Policy. Coming of Age: Toward A National Retirement Income Policy. Technical appendix, chapter 30.

In conclusion, the data on savings are not satisfactory. Many questions remain unanswered. But based on what we do know, because of the tax changes and the demographic changes, savings could well play a larger role in supplying income to the elderly in the future, although probably not for the low-income elderly.

# Chapter 6

# EMPLOYMENT

Many of our current employment and pension policies were designed more than half a century ago. They were based on perceived need to encourage older workers to retire in order to make room for a growing number of younger workers. Until the mid-1970's, favorable demographic and economic conditions permitted the social security system and many other retirement income programs to build adequate financial reserves. These conditions led employers to assume that they could afford to expand early retirement practices, and policies designed to ease "unneeded" older workers out of the market became widespread.

Today, the favorable conditions of earlier times no longer exist. Our Nation now faces mounting pressures brought about by slower economic growth, high rates of inflation and a larger aged population which is living longer in retirement. At the same time, the labor force participation rate has dropped from 87 percent in 1960 to 70 percent in 1983. Older workers are caught between the traditional employment and retirement policies of the previous two decades urging them to get out of the work force early, and the economic insecurities and desire to stay productive driving them to continue working.

There are several reasons for both Federal and industry concern about the continuing decline in labor force participation for older persons. First, the future economic position of an older person may be endangered by early labor force withdrawal since longer periods of retirement are now anticipated under conditions of sustained inflation; second, earlier retirements increase the financial stress on both social security and private pension plans; third, shortages of skilled labor could develop in certain industries; and fourth, it appears that older persons' preferences for part-time employment are increasing but that labor demand is not sufficient to satisfy their current employment needs. Therefore, the potential for reversing the decline in labor force participation rates and removing the obstacles to continued employment have become major public policy issues.

Congress recently focused on whether there is too great an incentive to retire early during debate on the Social Security Amendments of 1983. These amendments clearly point in the direction of longer worklives in the future. However, the earnings limit in social security and the nonaccrual of private pension benefits beyond age 65 remain a disincentive to continued employement for at least a portion of the older work force. Additionally, age discrimination continues as a factor in blocking employment of older workers. More effective enforcement of the Age Discrimination in Employment Act is required.

Although a number of larger corporations are taking the lead in capitalizing on the skills and experience of older workers, these are usually "showcase" examples and have not significantly increased employment opportunities for older persons. More progress is needed in this area among small- and medium-sized businesses where most older workers are actually employed. Strong corporate inducements to retire early remain attractive alternatives to continued employment. The general impression that older workers cost employers more than younger workers persists. Although this impression has not been substantiated in research, employers appear to have a valid case, especially with regard to health insurance costs.

Both Government and the private sector face the urgent challenge to develop employment policies and programs that make extended worklife an appealing proposition in lieu of retirement, otherwise the current trend toward early retirement will continue and the future stability of our retirement income systems may be further jeopardized.

## A. OLDER WORKERS IN THE U.S. LABOR FORCE: A PROFILE

### 1. The Older Worker Labor Force—November 1983

Nearly 30 percent of the 1.7 million people employed in the United States in November 1983 are 45 years old and over. There are over 12 million workers between the ages of 55 and 64 in the labor force—7.2 million men and 4.8 million women. These older workers make up 13.5 percent of the U.S. labor force. There are a total of 3 million workers age 65 and over in the labor force—1.9 million of these are men and 1.2 million are women.

Labor force participation rates for men aged 65 and over have dropped from 34 percent in 1960 to 17.6 percent in November 1983.[1] For men aged 55 to 64, the rate has dropped from 87 percent in 1960 to 70 percent in November 1983.

The participation rate for women age 65 and over remains low. In 1960, slightly over 10 percent of this group was in the labor force. In November 1983, that rate was 7.8 percent. There has been a slight increase in labor force activity for women aged 55 to 64. In 1960, the rate was 37 percent. In November 1983, the rate was 41.3 percent. The following table presents a labor force profile of older workers as of November 1983.

---

[1] The U.S. labor force includes workers who are employed and actively seeking employment. The participation rate is the percentage of individuals in a given group (e.g., age group) who are in the labor force.

## TABLE 1.—LABOR FORCE STATISTICS ON OLDER WORKERS BY AGE AND SEX, NOVEMBER 1983

[In thousands]

| | 55 to 64 years old | | | 65 or more years old | | |
|---|---|---|---|---|---|---|
| | Total | Male | Female | Total | Male | Female |
| Labor force status (seasonally adjusted): | | | | | | |
| Civilian labor force | 12,051 | 7,195 | 4,856 | 3,074 | 1,872 | 1,202 |
| Labor force participation rate (percent) [1] | 54.7 | 70.0 | 41.3 | 11.8 | 17.6 | 7.8 |
| Number unemployed | 639 | 433 | 206 | 102 | 64 | 39 |
| Unemployment rate (percent) | 5.3 | 6.0 | 4.2 | 3.3 | 3.4 | 3.2 |
| Number employed | 11,412 | 6,762 | 4,650 | 2,971 | 1,808 | 1,163 |
| Full- and part-time status (not seasonally adjusted): | | | | | | |
| Number employed | 11,481 | 6,789 | 4,691 | 3,000 | 1,817 | 1,183 |
| Employed part time: | | | | | | |
| For economic reasons | 537 | 236 | 300 | 133 | 89 | 44 |
| As a matter of choice | 1,502 | 375 | 1,127 | 1,470 | 783 | 686 |
| Employed full time | 9,442 | 6,178 | 3,264 | 1,397 | 945 | 453 |
| Duration of unemployment (not seasonally adjusted): | | | | | | |
| Number unemployed | 589 | 372 | 216 | 103 | 62 | 40 |
| Less than 5 weeks | 177 | 86 | 91 | 29 | 13 | 15 |
| 5 to 14 weeks | 129 | 76 | 52 | 27 | 16 | 11 |
| 15 to 26 weeks | 77 | 46 | 31 | 19 | 14 | 5 |
| 27 or more weeks | 206 | 164 | 42 | 28 | 19 | 9 |
| Average (mean) duration (in weeks) | 28.9 | 35.0 | 18.5 | 23.3 | 25.5 | 19.9 |
| Median duration (in weeks) | 13.8 | 21.2 | 8.4 | 10.6 | 16.2 | 9.2 |

[1] The U.S. labor force includes both individuals who are employed and individuals who are actively seeking employment (unemployed). The participation rate is the percentage of the eligible worker population for a given group (e.g., age group) that is in the labor force.

Source: U.S. Department of Labor, Bureau of Labor Statistics, Current Population Survey.

## 2. INDUSTRIAL TRENDS OF OLDER WORKERS

The U.S. economy has been shifting from agriculture and heavy industry to service and light industries. The shift from physically demanding or hazardous jobs to those in which skills and knowledge are the important requirements will increase the potential for older workers to remain in the labor force longer.[2]

According to employment projections, many working elderly today hold jobs in industries that can expect the greatest employment increases (see table 2). Of the projected 1981–90 increase in employment of 17 million workers, over 75 percent is expected to occur in the two largest industries—wholesale and retail trade and services. These two industries currently employ 60 percent of all workers age 65 and older.

## TABLE 2.—EMPLOYMENT BY INDUSTRY, CALENDAR YEARS 1981 AND 1990

| Industry | 1981 | | 1990, all ages [1] | Projected change in employment, 1981–90 | Average annual percent change in employment |
|---|---|---|---|---|---|
| | 65+ | All ages | | | |
| All industries (in thousands of persons) | 3,119 | 107,348 | 124,186 | 16,838 | 1.6 |
| Distribution (in percent) | 100.0 | 100.0 | 100.0 | | |
| Agriculture | 9.2 | 3.0 | 2.0 | −717 | −2.8 |
| Mining | .4 | 1.0 | .8 | −70 | −.7 |
| Construction | 3.8 | 6.4 | 6.3 | 975 | 1.5 |
| Manufacturing—durables | 6.1 | 13.4 | 12.4 | 1,019 | .8 |

---

[2] Personick, V. The Outlook for Industry Output and Employment Through 1990. Monthly Labor Review, pp. 28–55, August 1981.

## TABLE 2.—EMPLOYMENT BY INDUSTRY, CALENDAR YEARS 1981 AND 1990—Continued

| Industry | 1981 | | 1990, all ages [1] | Projected change in employment, 1981–90 | Average annual percent change in employment |
|---|---|---|---|---|---|
| | 65+ | All ages | | | |
| Manufacturing—nondurables | 5.6 | 8.8 | 7.4 | −242 | −.3 |
| Transportation | 3.2 | 6.3 | 6.0 | 630 | 1.0 |
| Trade—wholesale and retail | 23.6 | 20.5 | 22.7 | 6,194 | 2.8 |
| Finance, insurance, and real estate | 6.1 | 5.9 | 5.9 | 1,010 | 1.6 |
| Services | 37.8 | 29.5 | 31.3 | 7,156 | 2.3 |
| Public administration | 4.2 | 5.2 | 5.2 | 883 | 1.7 |

[1] Employment levels are averages of BLS low and high-1 employment forecasts, which correspond to annual increases in employment from 1979 through 1990 of 1.4 and 2.1 percent, respectively. Employment in the service industry includes BLS service and private household categories; employment in public administration includes only those civilian government workers whose employment is not categorized in other industries in the Current Population Survey.

Sources: CBO tabulations based on U.S. Dept. of Commerce, Bureau of the Census. Current Population Survey, March 1981; and Valerie A. Personick. The Outlook for Industry Output and Employment Through 1990. Bureau of Labor Statistics (BLS). Monthly Labor Review, v. 104, August 1981.

Over 70 percent of the projected overall increase in employment also is expected to occur in three occupations in which many elderly currently work (see table 3). These occupations—service, professional-technical, and clerical—are the three largest employers of the elderly today.

## TABLE 3.—EMPLOYMENT BY OCCUPATION, CALENDAR YEARS 1981 AND 1990

| Occupation | 1981 | | 1990, all ages [1] | Projected change in employment 1981–90 | Average annual percent change in employment |
|---|---|---|---|---|---|
| | 65+ | All ages | | | |
| All occupations (in thousands of persons) | 3,119 | 107,348 | 123,775 | 16,403 | 1.6 |
| Distribution (in percent) | 100.0 | 100.0 | 100.0 | | |
| Professional-technical | 13.3 | 15.7 | 16.6 | 3,777 | 2.3 |
| Managers-administrators | 13.2 | 11.2 | 8.8 | −1,173 | −1.1 |
| Sales | 10.3 | 6.2 | 6.7 | 1,652 | 2.5 |
| Clerical | 14.1 | 18.4 | 18.6 | 3,271 | 1.7 |
| Craftsmen | 7.3 | 12.8 | 12.1 | 1,209 | .9 |
| Operatives | 8.9 | 14.4 | 13.7 | 1,570 | 1.1 |
| Nonfarm laborers | 3.9 | 4.7 | 5.8 | 2,182 | 4.1 |
| Private household | 4.1 | 1.2 | .8 | −325 | −3.1 |
| Service | 16.3 | 13.0 | 15.0 | 4,554 | 3.2 |
| Farmworker | 8.6 | 2.4 | 1.9 | −314 | −1.4 |

[1] Employment levels are averages of BLS low and high-1 employment forecasts.

Sources: CBO tabulations based on U.S. Department of Commerce, Bureau of the Census, Current Population Survey, March 1981; and Max L. Carey. Occupational Employment Growth Through 1990. Bureau of Labor Statistics (BLS). Monthly Labor Review, v. 104, August 1981.

Those industries and occupations employing the largest numbers of elderly in 1981 are also the same as those that had the largest absolute growth in employment during the previous decade. The service and trade industries together accounted for over 50 percent of industry employment growth; and the professional-technical, manager-administrator, clerical, and service occupations represented 75 percent of occupational employment growth.

### 3. THE GROWING NUMBER OF UNEMPLOYED OLDER PERSONS

Older workers age 55 and over generally experience unemployment rates under the national average. In December 1983, 4.9 percent of the civilian labor force age 55 and over was unemployed—

compared to 8.6 percent for those age 54 and younger. But older workers who lose their jobs for various reasons including plant closing, business mergers, and economic conditions have more difficulty becoming reemployed. In searching for new employment, older workers have to compete against younger persons with more recent education and training. They may be seeking higher wages and salaries than those with less experience and the cost of their fringe benefits such as insurance and pensions may be higher.

As a result of the above factors, the length of unemployment tends to be longer for older workers. People age 55 and over are out of work on the average nearly 20 weeks before being reemployed. That is 23 percent longer than the 15.5 weeks between jobs, on the average, for all unemployed Americans. (While the youngest workers have the highest unemployment rates, they are out of work the briefest periods of time—an average 14 weeks for those age 20 to 24, 10 weeks for those age 16 to 19.)

### 4. PART-TIME EMPLOYMENT [3]

Despite the trend toward early retirement, surveys consistently show that there is a strong interest among older people in continuing some form of work after retirement, usually part time. Although the interest exists in part-time work, there is a contradiction between the interest and what appears to be the reality of limited part-time employment opportunities.[4]

According to a 1981 Harris survey, older workers, especially those age 65 and over, desire and seek part-time work. Interviews with older persons revealed signs of a constant, perhaps increasing, emphasis on their wanting to remain active in society, primarily as paid employees. Seventy-eight percent of the employed persons responding would like to continue part-time jobs.

However, evidence from research conducted in 1983 by the Public Research Institute for the National Commission on Employment Policy indicated that, despite statements by older workers that they have a strong interest in part-time work, in most cases retirement is sudden and complete. Most older workers retire completely without a transition period of part-time work. This explanation for sudden retirement is supported by a wide variety of evidence: (1) The employment costs themselves, (2) the lower pay for part-time workers, (3) the scarcity of part-time jobs for workers of all ages, (4) the prevalence of layoffs rather than reduction in hours among married women and students, and (5) the concentration of part-time work in low-wage industries.

The study found that older workers are likely to retire completely rather than work part time because of low compensation for part-time work. The study concluded that this would be true even if: (1) There was a reduction of employment cost (such as the employer's social security contribution), (2) the social security earnings limit was removed, or (3) a subsidy existed for hiring older workers.

---

[3] Part-time work is defined by the Department of Labor as ranging between 1 and 34 hours per week. These data are not seasonally adjusted.

[4] In 1983, 832,000 male workers and 709,000 female workers age 65 and over worked part time. Those who do work part time are usually self-employed. Among those employed by others, part-time workers are concentrated in particular industries—agriculture (32 percent); finance, insurance, and real estate (24 percent); and personal service (28 percent). They are least common in manufacturing (6 percent), transportation/communications and public utilities (10 percent).

### 5. The Early Retirement Trend

Age 65 may be the stated norm for retirement, but it is becoming the exception, in fact. Most older workers are claiming retirement benefits at age 62.

In recent years, public attention has focused on early retirement because of its costs to social security. In the Social Security Amendments of 1983, Congress sought to encourage delayed retirement by gradually raising the age at which full social security benefits can be received to age 67 from age 65 and by gradually increasing the benefit 8 percent a year for each year retirement is delayed.

However, based on research conducted for the National Commission for Employment Policy by Fields and Mitchell, the effects on retirement patterns of such a change will be minimal—increasing the average retirement age by only about 3 months. While the legislation did increase the incentives for later retirement, the study, which analyzed how older people responded to incentives in the past, indicates these new incentives by themselves are not great enough to change retirement patterns very much.

The authors, in their paper "Restructuring Social Security: How Will Retirement Ages Respond," investigated a variety of incentives that could be incorporated in the social security legislation, including raising benefits for later retirement. The study found that other options, such as reducing early retirement benefits, would also have little effect on most workers' retirement age.

People retire at a given age for a variety of reasons—such as health availability of private pension benefits, social expectations, and long-held plans. The increase in social security benefits that occurs when retirement is delayed is only one of these.[5]

A provision in the Social Security Amendments of 1983 calls for the Secretary of Health and Human Services (HHS) to study the law's implications for workers who, because they are engaged in physically demanding jobs or are unable to extend their working careers for health reasons, may not benefit from improvements in longevity. A full report, including any recommendations for providing protection against risks associated with early retirement due to health reasons, is due to be submitted to Congress by January 1, 1986.

## B. EMPLOYER DISINCENTIVES TO CONTINUED EMPLOYMENT

The Age Discrimination in Employment Act (ADEA) prohibits mandatory retirement until age 70. However, the combination of the recession's impact of increasing labor supply and the relative costs of employing older versus younger workers has led employers to offer very strong "inducements" for workers to retire early.

---

[5] Fields and Mitchell. Restructuring Social Security: How Will Retirement Ages Respond. Part of Research Report Series for the National Commission on Employment Policy. Summer, 1983. Executive Summary.

## COSTS OF EMPLOYING OLDER WORKERS

There is a dearth of empirical information to discern whether it costs more to employ older workers than younger workers. But a general impression persists that older workers are more expensive and may be inhibiting employers from encouraging employment of them. The higher costs that would have to be borne are in such areas as compensation, health and life insurance, and workers' compensation if more older workers were in the picture. In some cases, pension plan costs would be much higher for a worker who retired at age 70 instead of age 65.

Employers' concerns about the rising cost of providing health insurance to older workers may be valid. In the last decade there has been an increasing trend by the Federal Government to seek ways to curb the rising costs of medicare. One such proposal to limit costs, included in the Tax Equity Act of 1982 (TEFRA), legislated changes in medicare coverage for older workers. This change was prompted primarily by the desire to save medicare expenditures. Since January 1983, employers can no longer advise workers that they are to be dropped from company group health insurance plans at age 65 because they are eligible for medicare. TEFRA requires that company plans bear the primary insurance costs of an illness; medicare may pick up some of the costs not covered by the company plans.

The TEFRA requirement will raise employer costs in two ways. First, costs will rise for employees age 65 through 69 who previously were covered by employer plans, because these plans now are the primary payer of benefits rather than supplementing medicare. Second, employees age 65 through 69 who previously were excluded from employer health plans must now be covered if the employer offers a plan to any employees.

A report released in June 1983, by ICF, Inc., estimated that about 434,000 private sector workers age 65 through 69 (about 37 percent of all private sector of this age) will be affected by these changes, at a total cost to employers of about $500 million. About 286,000, or 66 percent, of these workers were previously covered by employer plans. The additional health plan costs for these workers are estimated to be about 8 percent of their total compensation costs before the amendments. About 148,000 workers who were previously excluded are likely to be covered by employer plans. The health plan costs of these workers is estimated to be about 13 percent of their total compensation costs before the amendments. The study concludes that these changes may initially reduce the demand for workers of this age by about 1 percent.

According to the Wall Street Journal, some insurance companies are taking into account the number of older workers in a firm when quoting group rates for workers. This is particularly a problem for small firms where most older workers are employed. The article states that insuring small groups has been a losing proposition for large insurers because of cutrate competition from smaller insurers and the escalating medical costs that have caused health-insurance claims to soar. Companies that still cover small groups are being more selective, refusing to insure groups with more than a few older employees in them.[6] If employers were to ask insurance companies for policies with unreduced benefits for older workers, the costs would be much higher, and some employers are likely to resist assuming this additional cost of labor.

Because of the lack of information on employment costs of older workers, the Senate Aging Committee along with the Employee Benefit Research Institute will, in 1984, conduct a study on "The Costs of Older Workers." The study will document specific cost areas including direct compensation, various employee benefits, turnover, and work options. The study will review cost issues from a broad human resources perspective and will discuss such issues as performance and productivity.

## C. CORPORATE INCENTIVES TO EARLY RETIREMENT

Most of the incentives in the present pension system are incentives to early retirement. The decision to offer an attractive "out" to an older employee is often considered a necessary tradeoff for the maintenance of jobs for younger workers. Employers encourage early retirement by allowing better than actuarially fair benefits to be paid to early retirees for a few years until social security payments are available. Some employers offer pension "supplements" to their employees which are paid to a pensioner until social security benefits become available. The retirement income remains about equal as social security replaces the supplements. The supplements make the retirement decision an economically feasible one far before it would have been otherwise. Employers may also offer the "open window" or "golden handshake" option which offers the employee a very attractive lump-sum benefit and early pension benefits in exchange for the employee's early retirement. The open window has also come to be associated with coercive action on the part of the employer when attempting to retire older workers.

Examples of these types of plans, as cited in the BNA Weekly Reporter, follow:

### 1. Aluminum Producers

Three major aluminum producers reached agreement with two unions on new 3-year contracts that include provisions for special early retirement incentives. The firms agreed to a plan to give older employees an incentive to retire early. Under the provision, employees who are at least 60 years old with 30 years of service (often referred to as "30 and out"), and who were due to retire in June or July 1983, receive a special $400 per month pension supplement for 1 year or until they reach age 62. About 700 workers were eligible to choose the option.[7]

---

[6] Wall Street Journal. Wednesday, Nov. 21, 1983. p. 27.

[7] Bureau of National Affairs, Inc. BNA Weekly Reporter, Washington, D.C. v. 10, June 6, 1983. p. 977.

### 2. TRANSPORT WORKERS/AMERICAN AIRLINES

Members of the Transport Workers Union ratified a 3-year contract at American Airlines that also included a special early retirement provision.

Under the contract, employees between the ages of 50 and 55 with 15 years of service would receive a supplemental retirement benefit of $5,000 per year, provided they retired by April 1, 1983. Regular early retirement would begin at age 55 under the special early retirement provision.

In an effort to trim employment rolls, the parties also agreed to a severance benefit of $10,000 for any employee who leaves American, regardless of age or seniority.[8]

### 3. CWA-GTE

The Communications Workers of America and General Telephone of California ratified a 3-year contract in early 1983, with features to encourage older employees to retire early.

The contract included two different plans to soften the effect of layoff or termination on employees. Under the plan, workers with 20 or more years' service whose jobs were eliminated because of technology were entitled to their full service pension plus an additional $200 to $400 per month for up to 4 years of separation. The employees were also eligible to receive an additional $3,000, which they could elect to receive in one of three ways: (1) as payment toward their medical insurance premiums for up to 4 years after separation, (2) as reimbursement for successful completion of a retraining course in another field, or (3) as a reimbursement for moving expenses.[9]

## D. FEDERAL INCENTIVES AND DISINCENTIVES TO CONTINUED EMPLOYMENT

The Federal Government significantly influences the work and retirement decisions of older persons. The increasingly earlier utilization of social security and private pension benefits and the continuation of mandatory retirement practices have recently led Congress to examine whether the Federal Government provides too great an incentive to retire early, and whether there are too many disincentives to continued employment.

### 1. MANDATORY RETIREMENT

The Age Discrimination in Employment Act (ADEA) of 1967 prohibited employment discrimination against persons aged 40 to 65. The upper age limit was set at 65 because it was the common retirement age in U.S. industry and the normal retirement age for full social security benefits. In 1978, the act was amended to extend protection beyond age 65, without any age limit for employees of the Federal Government and until age 70 for most other workers. At present, 28 million persons—7 out of every 10 workers between the ages of 40 and 70 are protected by the ADEA.

---

[8] Ibid. v. 10, Mar. 14, 1983. p. 640.

[9] Ibid. v. 10, Apr. 11, 1983. p. 462.

According to the Department of Labor (DOL) the major short-term impact of the 1978 ADEA Amendments was to force employers to raise their mandatory retirement age limits. The total long-term impact will likely be determined largely by changes in other Federal retirement policies and future economic performance. (See section E of this chapter for further analysis of the ADEA).

### 2. Social Security

The compromises that resulted in the Social Security Amendments of 1983 (Public Law 98-21) clearly point in the direction of longer worklives in the future. In the long run, older workers will be encouraged to remain in the labor force through an increase in the penalty for early retirement, an increase in the age at which full retirement benefits are paid, an increase in the delayed-retirement credit, and a reduction in the penalty on earnings after retirement.

#### (A) INCREASED PENALTY FOR EARLY RETIREMENT

The early retirement age will remain 62—60 for widows—but the actuarial reduction factor for early retirement will increase due to the increase in the full retirement age. For those retiring at age 62, the reduction factor, now 20 percent, will rise to 30 percent. Medicare benefits will continue to be available at age 65.

#### (B) INCREASE IN AGE ELIGIBILITY FOR FULL BENEFITS

The age at which full social security retirement benefits will be paid will rise from 65 to 67 in two stages. For those who reach age 62 beginning in the year 2000, the retirement age will increase by 2 months a year until it reaches age 66 for those turning 62 in 2005. For those reaching age 62 beginning in 2017, the retirement age will again increase by 2 months a year until it reaches 67 for those turning 62 in 2022. Thereafter, the retirement age will remain at 67.

#### (C) INCREASE IN THE DELAYED RETIREMENT CREDIT

Beginning in 1990, the delayed retirement credit, an adjustment to monthly benefits that compensates workers who defer receiving benefits after the normal retirement age of 65, will gradually increase. The current credit of 3 percent per year provides less than a full actuarial increase in benefits, resulting in a benefit loss to workers who delay retirement. The new provision raises the credit by one-half of 1 percent every other year until it becomes an 8 percent annual credit for workers reaching age 65 after 2007. An 8 percent credit is the equivalent of a full actuarial increase and should eliminate the current penalty for delayed retirement.

#### (D) REDUCTION IN THE PENALTY ON EARNINGS AFTER RETIREMENT

Beginning in 1990, beneficiaries aged 65 and older will lose $1 in social security benefits for every $3 in earnings above the exempt amount—$6,600 in 1983—rather than $1 for every $2 at present.

From the perspective of the older worker, the earnings limit currently penalizes continued work by making benefit receipts conditional on at least partial labor force withdrawal. In 1983, retirees 65 to 71 lost $1 in benefits for each $2 they earned above the exempt amount $6,600; retirees 62 to 64 lost the same amount for earnings above $4,400. This is equivalent to a tax of 50 percent on those extra earnings, in addition to the social security payroll tax and Federal and State income taxes. Benefits are not reduced by the amount of unearned income—including dividend and interest income from investments and private pension benefits.

The tax-free status of social security and parts of some pension benefits have been important factors in the thinking of older people about working again. They hesitate to lose tax-free benefits in return for taxable wages, and most of them do not believe they could net enough wages after the loss of benefits to bring them more income.

### 3. NONACCRUAL OF PRIVATE PENSION BENEFITS AFTER AGE 65

Under the present interpretation of the 1978 amendments to the Age Discrimination in Employment Act (ADEA), pension plans regulated under the Employee Retirement Income Security Act (ERISA) are not required to continue accrual of pension credits for employees who work beyond normal retirement age. Presently, 50 percent of the plans covered by ERISA do accrue benefits after age 65. Assuming the mandatory retirement limit of age 70 was retained and private pension plans were required to continue accrual of pension credits, an estimated 50,000 more workers age 60 to 70 would be employed by the year 2000. If the age 70 limit was removed as well, a total of 68,000 more men age 60 to 70 probably would be in the work force by that year.[10] These statistics suggest that the discontinuation of pension benefit accruals are a significant disincentive for continued employment beyond age 65 for a least a portion of the work force.

After the 1978 amendments to the ADEA, the Department of Labor (DOL) published an interpretive bulletin on the act in May 1979. Section 4(f)(2) of the DOL interpretation allowed employers to cease pension contributions and crediting for active employees who work beyond the normal retirement age specified in their pension and retirement plans. Specifically, these rules interpret the ADEA to permit pension plans to: (1) Cease employer contributions at "normal retirement age" (65 years of age under most plans); (2) not credit years of service, salary increases, and benefit improvements which occur after an employee reaches the normal retirement age specified in the plan; and (3) not adjust actuarially the benefits accrued as of normal retirement age for an employee who continues to work beyond that age (29 C.F.R. 860.120).

Shortly after the publication of these interpretations, the administrative and enforcement authority under the ADEA was transferred from DOL to the Equal Employment Opportunity Commission (EEOC). The EEOC commenced a review of the factors relevant to the DOL interpretation by requesting public comments on the continuation of present practices (see, 48 F.R. 41436, Sept. 15,

---

[10] U.S. Dept. of Labor. Interim Report: Studies on the Effects of Raising the Age Limit in the Age Discrimination in Employment Act. December 1981, p. 223.

1983). Numerous groups and individuals responded to the request, providing the EEOC with hundreds of pages of information, most of which supported prohibiting employers from discontinuing pension benefit accruals at the normal retirement age. EEOC was continuing to evaluate the public responses as 1983 came to a close.

Proponents of continued pension benefit accruals beyond normal retirement age have argued that the DOL/EEOC interpretations, insofar as they permit pension benefits to be frozen or suspended, are contrary to ADEA's policy promoting employment of older persons by prohibiting employer discrimination against older employees because of their age. Reversing the 1979 interpretation would advance the individual civil rights of older employees by treating older workers as individuals and not as members of a disadvantaged group. From this viewpoint, freezing pension benefits at normal retirement age confers an undeserved windfall on employers. They suggest that the purpose of pension plans, to increase the retirement income of the elderly, could be furthered at little or no increased marginal cost to the employer by extending the accrual of pension benefits beyond normal retirement age.

Supporters of the current interpretations oppose any change in the status quo on the grounds that a change in the rules would cost employers an exorbitant amount of money. Employers argue that when the Employee Retirement Income Security Act (ERISA), which regulates private pension plans, was enacted, Congress unequivocally determined that retirement plans would not be required to recognize employment beyond normal retirement age either by accruing benefits or by actuarial adjustments to existing benefits. Further, they suggest that section 4(f)(2) of ADEA authorizes certain reductions in employee benefits on the basis of age. If this viewpoint is correct, and the ADEA amendments were not intended to change the intent manifested by Congress at the time ERISA was passed, then legislation will be necessary to require employers to continue benefit accruals.

Although the continued accrual of pension benefits would represent an increased cost for employers who presently freeze benefit accruals at normal retirement age, several factors suggest that requiring continued accruals would not overburden affected employers. At present, half of all plan sponsors already permit continued accrual, apparently without putting an undue strain on their plan. This is largely due to the employers' ability to fund such continued accruals over the entire length of an employee's career, spreading out the cost to make it more manageable. Recent employment trends have shown a preference amongst many employees for early retirement rather than extended employment. It is unlikely that an employer would be faced with large numbers of employees wishing to work beyond normal retirement age.

In a 1983 National Opinion Panel Survey conducted by the International Foundation of Employee Benefit Plans, 78 percent of the 123 panelists responding felt that employers should be required to continue pension plan contributions for employees who choose to work beyond age 65. Summing up the majority opinion, an anonymous panelist said:

> So long as one is employed in regular work, regardless of age, he or she should be entitled to full benefits, pension, or otherwise.

Some panelists felt that a more workable approach should be optional and voluntary, the survey found. An employee should be entitled to pension (profit-sharing) contributions from the time of minimum participation age is reached and for as long as the employee continues to work, but should not have to start receiving benefits before retirement, according to the survey.

The Senate Aging Committee plans to examine the pension accrual issue further in 1984. The committee will sponsor research to determine the actual cost of requiring employers to continue accrual of retirement benefits beyond the normal retirement age.

## E. PRIVATE SECTOR UTILIZATION OF EMPLOYMENT OPTIONS

The desire of older workers to stay on their jobs with reduced hours has been a major factor in the changing attitudes and policies favoring alternative work scheduling. As mentioned earlier, permanent part-time work is becoming the favorite option of older employees.

Employers too, may benefit from alternative work option programs such as flextime and shared time. However, many, if not most, of the programs are experimental in nature, have been introduced by only a small number of firms, and have relatively few participants. Generally, the programs are unrelated to other personnel and employee benefit policies—which may explain the relatively low participation rates. Work options programs usually are not linked with an overall human resources management approach.

With the advent of new work schedules in our society, some new descriptive terms have developed:

—*Job sharing:* Two workers share the responsibilities and benefits of one full-time job, each working part time.

—*Flextime:* Starting and quitting hours are chosen by workers themselves within limits set by management. Usually the entire staff is present during "core" hours, such as from 10 a.m. to 3 p.m.

—*Work sharing:* As a means of preventing layoffs and reducing employment during times of economic hardship, employees voluntarily reduce their working hours temporarily.

—*Permanent part time:* Employees work less than the standard 40 hours a week but receive better wages and benefits than what are traditionally associated with part-time work. Permanent part time often extends into management and administrative positions and employees receive pro-rated benefits.

—*Compressed workweek:* Workers put in their total hours in fewer days, such as 4 10-hour days instead of 5 8-hour ones.

—*Flexi-place:* Employees work at home or at other offices near their homes to cut down on commuting time.

—*Job redesign:* Instead of laying off aging workers or those with physical limitations, work stations and tasks are redesigned to accommodate physical problems workers may have or develop.

These alternative work options are most viable when recognized as mutually beneficial by the employer and the older worker.

### 1. Corporate Use of Employment Alternatives

Progressive business and corporate leaders are acutely aware of the changing structure of the American labor force. Coupled with responses to recent legislative changes concerning mandatory retirement, this awareness of the growing number of older workers has been translated into policy changes at the level of the individual company.

These policy changes and their resultant trends within companies were analyzed and prepared in two papers for the National Commission for Employment Policy and released in 1982, representing the most current "state of the art." The first report, "Emerging Employment Options for Older Workers: Practice and Potential, An Evaluation,"[11] gives information concerning the structure of employment options, the key employer, and public sector policy variables influencing decisions to use options, and the form of such options. Managers responsible for the design, administration, and modification of programs providing special employment options for older workers were interviewed. Policymaking managers in Government were contacted to ascertain the role of Government institutions in influencing public and private employer decisions in providing options for older workers.

The second report, "Innovative Employment Practices for Older Americans,"[12] expands, analyzes, and evaluates innovative program information collected as part of the national older worker information system, a computerized system funded by the Administration on Aging, containing information about innovative employment practices for middle-aged and older adults. Highlights of each executive summary of each report follows:

#### *Emerging Employment Options for Older Workers: Practice and Potential, An Evaluation*

> Helping older Americans to continue working, or return to work, is an issue of mutual concern to Federal, State, and local governments, to employers, and to the aged themselves, each for different reasons. The government is concerned with insuring adequate income and quality of life for the aged, as well as reducing dependence on public welfare. Private sector employers are interested in employment options because they are experiencing a growth in the number of older employees, because they desire to promote a positive image of themselves, and because older workers can, in some cases, be more productive. Furthermore, as the number of skilled workers entering the work force decreases, retaining older workers may be essential. Public sector employers have some of the same concerns,

---

[11] Gollub, Henton, and Waldhorn (SRI International), and Pul, Andrus Gerontology Center, U.S.C. Emerging Employment Options for Older Worders: Practice and Potential, An Evaluation. National Commission on Employment Policy. Washington, D.C., 1982.

[12] Root, Zarrugh, University of Michigan. Innovative Employment Practices for Older Americans. National Commission for Employment Policy. Washington. D.C., 1982.

but report that they are introducing changes in work arrangements more in response to pressure from the legislative and executive branches, and to some extent, unions, than out of concern for the efficiency of their operations or the welfare of older workers.

Overall, the context has been set for broader development of employment options for older workers. Regulatory policies, administrative changes, and experimentation with new models of employment assistance have established a framework on which more concerted efforts can be built. However, little linkage exists between the employment decisions of public and private employers and program activities designed to promote such employment options for older workers. At this point the need is to build on the successful innovations that have been developed, by promoting more systematic policy change that is sensitive to the conditions facing business, by spreading the concepts of new ways to work, and by encouraging better methods of linking older workers with labor market opportunities.

In order to develop policy strategies for Federal, State, and local governments that will help stimulate the availability of employment options for older Americans, an understanding of the practices of employers and how they are affected by the evolving policies of State and local governments is needed. To address this need, SRI International and the Andrus Gerontology Center at the University of Southern California carried out an evaluation of employer options for older workers and an analysis of State and local policy actions to encourage such options, to help develop a foundation for improving strategies.

The study, carried out under a contract from the National Commission on Employment Policy and the Department of Labor, included two research activities: An evaluation of seven types of work options for older workers in a sample of 25 business and government employers, nationwide, focusing on analysis of their program objectives, implementation requirements, and program consequences; an analysis of the policy actions taken by 15 State and 15 local governments in the areas of regulation and deregulation, tax policy change, program innovation, administrative reform, and public-private collaboration.

To accomplish the objectives of a broad strategy to increase employment options for older workers, policies at the Federal, State, and local levels could be developed. These might include:

*Federal level.*—Move beyond regulatory changes, such as eliminating mandatory retirement, perhaps emphasizing this at the State level. Consider tax credits for employer-provided training, or deductions for educational costs to the individual older adult. Insure that training employment programs, particularly those emerging under the Job Training Partnership Act, include older workers. Help such programs build on existing experience. Disseminate new work concepts about older adults. Develop employment brokerage services for the older worker. Promote development of national and local public-private partnerships to bring private resources and awareness to focus on older worker issues.

*State level.*—Build on past State regulatory innovation in ways sensitive to business conditions, particularly eliminating mandatory retirement and enabling permanent part-time work. Tax policy change is not likely to be an area of practical action, but linking older workers to assistance provided under economic development programs in the community may help. Developing State-level policy agendas should be a concern, emphasizing changes in regulatory and administrative practices in civil service—including job application procedures, eligibility, and job classification—and linkage of education systems to labor market needs. Using existing State resources in new ways should help expand existing services for older workers. States should consider working with private employers more in examining older worker issues, and encourage private industry councils to have older worker committees.

*Local level.*—There is a low probability that local regulatory or tax policies could be a useful area of activity, although some local jurisdictions may be more progressive than States. Administrative reforms seem to be a way to make the public employment system more helpful—by increasing job access, and by helping to redefine how public programs provide employment services to older adults. Program innovation in partnership with business should be a priority, including education of employers and older workers, as well as development of new types of brokerage services to fill labor market gaps.

*Nonprofit sector.*—Serve as a convenor and facilitator of business, government, and community interaction, as well as help develop and disseminate needed information to employers and older workers. Provide support for innovative models of employment service that have already been established.

Better linkages between public and private change already under way through education and brokerage of older workers, and appropriate changes in policies at different levels, can increase the array and quality of employment options open to older workers.

### *Innovative Employment Practices for Older Americans*

Many companies recognize the importance of older persons in the labor force, but barriers still exist which limit their productive employment. Negative stereotypes may influence hiring and promotion decisions and training opportunities to upgrade skills may be closed off. Minor disabilities may interfere with work routines and there may be limited options for part-time employment which grows in importance with age.

In this paper, we examine private sector employment programs/practices which are intended to increase employment options for older workers. Using the University of Michigan national older workers information system (NOWIS), a computerized information system containing descriptions of company programs/practices for older workers, an illustrative range of private sector approaches are analyzed to determine the extent to which different employment problems are addressed and how these programs/practices meet the personnel needs of the companies involved.

The analysis suggests that programs are successful when they are symbiotic—benefiting both the worker and the company. Approaches tend to focus on special programs to use needed technical or professional skills and/or to employ people for part-time or temporary work. Most of the programs involve white-collar workers and those programs for blue-collar workers primarily address service occupations.

Social security policies, the regulation of employee benefits, and the state of the economy have important implications for the employment of older workers. Private sector programs can be expected to expand with the growth in the proportion of older persons in the national labor force. We can expect these efforts may be limited, however, to situations in which a program or practice works to the mutual advantage of the employer and the older worker. This limitation may particularly affect blue-collar production workers and nonclerical white-collar workers.

## 2. JOB TRAINING PARTNERSHIP ACT

The new Job Training Partnership Act (JTPA), enacted by the 97th Congress, went into effect October 1, 1983, establishing a nationwide system of job training programs administered jointly by local governments and private sector planning agencies. Although the legislation itself specified no funding level for the new program, Congress appropriated $2.974 billion for the 9-month transition period from October 1, 1983 to June 30, 1984, and $3.626 billion for the 12-month program year from July 1, 1984 to June 30, 1985. The legislation requires that JTPA operate on a program year basis, running from July 1 to June 30 of each year, rather than a fiscal year basis.

JTPA establishes two major training programs: Title II for economically disadvantaged youth and adults, with no upper age limit; and title III for dislocated workers, including those long-term unemployed older workers for whom age is a barrier to reemployment. In addition, section 124(a–d) of JTPA establishes a statewide program of job training for economically disadvantaged workers aged 55 and older. Governors are required to set aside 3 percent of their title II allotments for this older workers program. During the 9-month transition period, this setaside amounts to $42.5 million. During the full program year, from July 1, 1984 to June 30, 1985, the older workers' setaside will be funded at $56.6 million. Nine-month funding for the entire title II program (excluding the summer youth employment program) is $1.415 billion; the program year is funded at $1.886 billion. The title III program for dislocated workers is funded during the 9-month transition period at $94.3 million; program year funding is $223 million.

The older workers program under section 124 of JTPA is meant to be operated in conjunction with public agencies, private nonprofit organizations, and private industries. Programs must be designed to assure the training and placement of older workers in jobs with private business concerns. A preliminary look at the program by the National Association of State Units on Aging indicates that some State Governors are appointing their State units on aging to administer the older workers' setaside.

### 3. Numerous Retraining Proposals Introduced

The 98th Congress shifted its attention from the training needs of the economically disadvantaged (which led to enactment of the Job Training Partnership Act in 1982), to the current and future retraining needs of workers who are neither poor nor unskilled, but who may be displaced from their jobs by changes in technology and the needs of the labor market. Numerous bills were introduced in the Senate reflecting this interest, although none was enacted.

Older workers who become dislocated would be among those eligible for all of the following proposals, although age is not usually used as an eligibility criteria. These proposals, sometimes contained in a larger legislation, include: An expansion of the new JTPA dislocated workers program (S. 493, Kennedy); tax incentives for private employers to provide training for certain workers, including those with obsolete job skills (S. 481, Specter; S. 1810, Nunn; H.R. 379, Roe; H.R. 807, Gaydos); legislation to require defense contractors to provide training as a condition of receiving Federal assistance (S. 242, S. Rept. 98-181, Quayle); proposals to expand training programs for workers displaced by imports under the Trade Act of 1974 (H.R. 3391, H. Rept. 98-281, passed by the House September 15, passed by the Senate November 18, Pease; S. 838, Metzenbaum; S. 749, Moynihan); block grants to States to be used as payments to employers who hire and agree to train eligible unemployed individuals, including those with obsolete skills (S. 649, Hatch); a new vocational education grant program to provide training, retraining, and placement services for workers aged 45 and older (S. 554, Pell); additional unemployment compensation for dislocated workers in training programs (S. 1085, Specter).

Although older persons are often eligible for employment and training programs, job retraining to equip workers for new jobs has often been unavailable to older workers. More often than not, the opportunity to participate in new learning experiences and retraining programs declines as a person approaches retirement. Reasons for this have included a belief on the part of employers that it was not worthwhile or cost effective to train older persons compared to younger persons because of the expectation of shorter worklives.

However, there may be reasons to believe that new training is complementary with previous training. That is, more highly experienced workers can learn new skills in a shorter period of time, thus reducing marginal training costs. To the extent that the prior experience of older workers makes them more trainable, the increase in marginal costs of training with age is reduced.

## F. AGE DISCRIMINATION BACKGROUND

Age discrimination in employment continues to play a pernicious role in blocking employment opportunities for older workers. It is not a new problem. According to the Department of Labor, the emergence of discriminatory employment practices for older workers can be traced to the late 1800's in the United States.[13] The most common of these practices were age limits for hiring and restrictive physical examinations. There is some evidence to indicate that even at this time, negative attitudes about the capacities and productivity of the aged were already common in the Nation. The development of retirement as a social pattern in industry may have served to enhance and legitimize employment discrimination practices despite early evidence that older workers were capable, conscientious and productive employees.[14]

Prior to 1920, age discrimination practices in employment were justified primarily on the basis of the belief that "modern technology" required substantial physical strength, agility, and endurance which was generally beyond the capacity of older workers. The requirements of industrial technology and efficiency were seen as causing the employment problems of the older worker, and justifying early discharge from employment.

Despite the gradual publication in the 1930's of industrial studies that demonstrated the advantages of older workers in terms of productivity, reliability, and physical capacities, limitations on employment of older persons persisted and grew largely because personnel managers and other corporate officials remained unconvinced of the productive capacity of older workers. Rigid age limits in hiring continued to be utilized to limit the number of older workers in the labor force.

These conditions led to early studies of age discrimination, most of which concluded that the technological environment combined with pensions, group insurance, and workmen's compensation, were responsible for the continuation of discrimination practices. Nevertheless, gradually and imperceptibly, a shift in beliefs about age discrimination occurred, with negative stereotypes about older workers becoming the dominant reason for the continuation of discriminatory employment practices.

With the passage of the Social Security Act in 1935, retirement as a social pattern gradually emerged in a society where age discrimination was already widely practiced. While age discrimination did not diminish in intensity, retirement permitted employers to arrange the work force so that younger workers were predominant and resulted in reducing the demand for employment by older workers. Gradually, early retirement policies, accompanied by continuing discrimination in employment based on age, became a consistent and a significant social pattern which resulted in substantial reductions in labor force participation by older persons.

---

[13] Historical information in this section is from an unpublished paper prepared by the Employment Standards Administration. DOL.

[14] Graebner, W., A History of Retirement, Yale University Press, New Haven, Conn. 1980.

### 1. AGE DISCRIMINATION IN EMPLOYMENT ACT OF 1967

The Age Discrimination in Employment Act (ADEA) was enacted in 1967 to "promote employment of older persons based on their ability rather than age; to prohibit arbitrary age discrimination in employment; and to help employers and workers find ways of meeting problems arising from the impact of age on employment." The act prohibited employment discrimination against persons aged 40 to 65. These age limits were chosen to focus coverage on workers especially likely to experience job discrimination because of their age. The upper age limit was set at 65 because it was the common retirement age in U.S. industry and the normal eligibility age for full social security benefits.

Since 1967, the ADEA has been amended twice. The first set of amendments occurred in 1974, when the provisions of the act were extended to include Federal, State, and local government employers. Also, the number of workers in establishments and labor organizations covered by the act was reduced from 25 to 20.

In 1978, the act was amended to extend protection beyond age 65, without any upper age limit for employees of the Federal Government and until age 70 for most other workers. Regulations implementing the 1978 amendments, however, specified that employers are not bound to credit years of service worked beyond age 65 to final pension benefit levels. This has and continues to be a disincentive to continued work beyond age 65.

Other features of the 1978 amendments were:

—No union or employer can arrange or collectively bargain for early retirement prior to age 70 as the condition for participation in an employee benefit plan.

—Compulsory retirement was permitted for bona fide executives and high policymakers at age 65.

—Colleges and universities were permitted to retire tenured employees at age 65 until July 1, 1982.

—A jury trial was authorized to determine issues of fact under any ADEA action.

—An aggrieved party was allowed to file a charge of age discrimination rather than a notice of intent to sue.

In eliminating the mandatory retirement age for Federal employees, exceptions were made for Federal prison guards, air traffic controllers, foreign service officers, and some other special groups.

### 2. REPORT TO THE CONGRESS ON AGE DISCRIMINATION IN EMPLOYMENT ACT STUDIES

The 1978 amendments also required the Secretary of Labor to conduct an extensive study on the consequences of the new coverage provisions of the law. The study was to examine the effects of raising the mandatory retirement age to 70, evaluate the probable consequences of eliminating this age, and review the effects of exemptions from the mandatory retirement age for tenured faculty members and certain business executives. The results of this study were submitted to Congress in a report at the end of 1982.

The executive summary of the report states:

> The Age Discrimination in Employment Act Amendments of 1978 (Public Law 95-256) required that the Secretary of Labor conduct an extensive study on the consequences of the new coverage provisions of the law including: (a) An examination of the effects of raising the upper age limit under the act to 70; (b) a determination of the feasibility of further extending or eliminating the age 70 limit; and (c) an examination of the effects of the exemptions in the law permitting mandatory retirement of tenured faculty members at institutions of higher education and certain business executives. The 1978 study requirements were placed in the context of a general requirement already in the ADEA, that the Department undertake an appropriate study of institutional and other arrangements giving rise to involuntary retirement and report findings and any appropriate legislative recommendations to the President and Congress. The amendments required that the Department of Labor report study findings to Congress in an interim report in 1981. Also, a final report on the studies, including departmental recommendations, was required to be submitted in 1982.
>
> In response to this requirement, the Department of Labor initiated in 1979, an extensive series of studies designed to produce information on the current and probable future consequences of the 1978 ADEA amendments. Research findings from most of these studies are summarized in this interim report. These findings include information on the labor force participation effects of mandatory retirement, response of current workers and employers to the increased mandatory retirement age, long-term projections of the consequences of mandatory retirement age alternatives, and the effects of the ADEA exemptions for tenured faculty at institutions of higher education and for executives. The interim report presents the most important research findings relevant to the major areas of congressional concern—the effects of raising the upper age limit in the ADEA to 70; the feasibility of extending or eliminating the upper age limitation; and the effects of the exemptions in the law for tenured faculty members and certain business executives.
>
> In conducting these studies, the Department of Labor was concerned with both the impact of mandatory retirement on individuals and the administrative and financial consequences of the ADEA amendments for employers. In addition the Department recognized that the retirement decision is simultaneously influenced by mandatory retirement policies, public and private pension policies, and personnel policies. The study findings in this report examine the consequences of mandatory retirement policies in the context of these other major factors influencing retirement behavior.

The Age Discrimination in Employment Act Amendments of 1978 represented a substantial modification of the provisions of the act by extending the upper age limit of protection under the act to age 70 for most private sector and non-Federal public employees, prohibiting mandatory retirement of covered workers under employee benefit plans, and extending age discrimination protection without an upper age limit to almost all Federal employees. In enacting these provisions, Congress was concerned about potential consequences of increasing the mandatory retirement age. The major areas of concern included: (1) The possibility of an adverse impact on employment opportunities for younger and minority employees resulting from large-scale retention of employment by workers after age 65; (2) potential administrative burdens on employers; (3) possible cost implications for pension plans; and (4) possible difficulties for universities and major corporations in adjusting to the upper age limit of 70.

## DEMOGRAPHIC AND RETIREMENT TRENDS

Two trends which have developed over the past 25 years are of major significance in considering the potential effects of the Age Discrimination in Employment Act—population aging and the decline in labor force participation by older workers.

Under intermediate demographic assumptions, the 65 and over population will increase from 25 million in 1980 (11 percent of the total population) to 32 million in the year 2000 (13 percent of the total population). The median age of the population which was 28 in 1970, is now 30 and will continue to increase. Contributing to population aging is the gradual increase in life expectancy; medical advances in the future could result in even greater life expectancy leading to higher proportions of older persons in the population. These trends will result in a gradual aging of the labor force in the coming years.

While the overall population continues to age, labor force participation by older workers has declined significantly over the past 25 years. For men 65 and over, labor force participation reached a new low of 19.3 percent in 1980 (28.5 percent of men 65 to 69 were labor force participants however). Declining participation was also occurring for men 55 to 64 and 45 to 54 years of age. Labor force participation by older women has been low but stable for many years.

It is generally agreed that the increasingly earlier availability of social security and private pension benefits and institutionalized mandatory retirement practices have led to the development and continuation of the early retirement trend and substantially lowered the labor force participation of older workers. A continuation of this trend will have two major consequences: (a) A substantially increased retirement financial support burden for a smaller work force; and (b) weak incentives for older persons to continue working in view of institutionalized mandatory retirement rules and income availability from pension programs. Declining labor force participation by older workers is of considerable concern since: (1) The economic position of retired persons will be significantly affected by longer periods of retirement and continued inflation; (2) early retirement increases the financial strain on the social security system and private pension programs; (3) shortages of skilled labor could develop in certain industries and geographical areas; and (4) older persons' preferences for part-time employment are growing but labor demand is not sufficient to satisfy their employment needs. For these reasons the potential for reversing the decline in labor force participation and raising or eliminating the mandatory retirement age are important major public policy issues.

### ESTIMATED NUMBER OF EMPLOYEES WITHIN SCOPE OF THE ADEA

An estimated 73 million workers of all ages are employed by employers having 20 or more employees and are, therefore, covered by the Age Discrimination in Employment Act. The exact number of these workers who are in the 40- to 70-year-old group protected by the act is not known. However, labor force data show that of the 105 million persons 16 years of age and older who were in the civilian labor force in September 1980, 39 percent were 40 to 70 years of age. Applying this proportion to the estimated 73 million persons employed by covered employers, yields an estimate of 28 million persons covered by the ADEA or 7 out of every 10 persons aged 40 to 70 in the civilian labor force.

The final report's major recommendations include:

(a) Eliminating the mandatory retirement age in the ADEA except for hiring and promotion where current law would remain applicable.

(b) Retaining the business executive exemption in the ADEA permitting compulsory retirement of certain executives at age 65 or over.

(c) Retaining a temporary exemption in the ADEA for tenured faculty members permitting their mandatory retirement at age 70.

(d) A congressional review of several important issues related to pension benefit provisions, hiring and promotion of older workers, and ADEA legal procedures; and

(e) Development of an information and technical assistance program by the Department of Labor to improve employment opportunities for older workers.

### 3. ENFORCEMENT OF THE ADEA

During the first 10 years after its passage, enforcement of the ADEA was the responsibility of the Department of Labor.

As a result of President Carter's Reorganization Plan No. 1 of 1978, implemented on June 22, 1979, by Executive Order 12144, enforcement responsibility for the ADEA shifted from the Labor Department to the Equal Employment Opportunity Commission (EEOC). The purpose of this shift was to consolidate all Federal enforcement of job-regulated civil rights in one agency.

Since the Commission first assumed responsibility for enforcement of the ADEA in 1979, the number of ADEA charges filed with the Commission has grown from 5,374 in fiscal year 1979 to 18,087 in fiscal year 1983, an increase of 330 percent. ADEA charges have also become a great proportion of the Commission's total caseload.

However, the number of cases actually filed in court by the EEOC under the age statute in the past 3 years is dramatically low in comparison with the number of age charges filed. In 1983, 33 lawsuits were filed, compared to 26 in 1982 and 89 in 1981.

Because antiage discrimination enforcement activities are of such critical importance, Chairman John Heinz initiated oversight proceedings of the EEOC in 1981. The objective of the oversight procedure was to examine the Commission's enforcement activity of the Age Discrimination in Employment Act since it assumed jurisdiction over the statute in 1979. The result of these proceedings was an oversight report, "EEOC Enforcement of the Age Discrimination in Employment Act: 1979 to 1982." This report represented the first thorough congressional oversight of the ADEA.

Findings and recommendations to strengthen ADEA enforcement made to the EEOC by the committee report included:

### (A) DIRECTED INVESTIGATIONS

*Findings:* The Commission has undertaken virtually no directed investigative activity under the ADEA. Instead, its resources have been targeted almost exclusively at individual charge resolution. As a result, directed investigations constituted less than 1 percent of the Commission's ADEA caseload in both fiscal years 1980 and 1981. In fiscal year 1980, the average number of directed investigations instituted per office was 3.8. The number of directed investigations per office bore little or no relationship to the office's charge intake or caseload. Rather, the failure to institute significant numbers of directed investigations seemingly stemmed from inadequate advance planning and insufficient priority attached to directed work. In addition, various institutional procedures and requirements apparently operate as a disincentive to the initiation of directed investigations.

The Commission claims that it has sustained an unanticipated increase in charge filings under the ADEA, which necessitated concentrating its resources in the area of individual charge resolutions. However, the increase in charge filings should not have come as a total surprise to the Commission. Historically, there has been an annual increase in title VII charge filings almost every year since the statute's enactment, thus, a certain annual increase in ADEA filings should also have been expected. In addition, the 1978 amendments to the ADEA may well have generated a higher level of public awareness, especially among older workers, as to rights under the ADEA. Moreover, the Commission's longstanding policy under title VII has been to accept all charges filed, even those which are dismissed for lack of jurisdiction. The Commission has adopted the same approach with respect to ADEA charges. This apparently is contrary to the former practice by DOL, where the filing of a number of charges which were either nonjurisdictional or appeared nonmeritorious were discouraged.

*Recommendation:* The ADEA's intent could be advanced by a more self-consciously directed program of investigation and targeted litigation rather than the reactive and limited litigation effort which now characterizes the EEOC's ADEA caseload.

### (B) LITIGATION STRATEGY

*Findings:* Under title VII, the Commission operates an independent office of systemic programs, with staffing in headquarters and the field, whose sole function is the development of systemic targets, investigation, and litigation of those cases. The Commission attaches a high priority to these title VII systemic enforcement efforts. By contrast, the Commission has dedicated no ADEA personnel or resources to the development of an ADEA systemic enforcement program. Rather, all ADEA enforcement responsibilities are consolidated into one age unit in headquarters, with corresponding offices in the field. These units are not expected or required to initiate systemic ADEA investigations or to develop ADEA systemic litigation targets. There is no apparent reasons for the difference in treatment with respect to systemic enforcement between the Commission's title VII and ADEA functions.

*Recommendation:* The Commission should institutionalize an ADEA systemic program and move promptly toward its implementation. When the enforcement function was transferred to the EEOC, the age attorneys were moved into title VII units. While they have always worked exclusively in the age areas, it may well be that with the growth of the ADEA litigation docket, it would be appropriate to create a separate age unit within the Trial Division. The creation of a separate unit would give ADEA issues greater visibility, facilitate monitoring, and effectuate the development of policy through litigation. With the corresponding greater visibility and significance that would attach to that unit, increased focus on systemic activities would be likely to follow.

### (C) INSTITUTIONAL EXPERTISE

*Findings:* The Commission risks losing its institutional expertise in ADEA law as a result of internal reorganization which combines title VII and ADEA functions at all levels. New charge-processing procedures may have affected ADEA enforcement in two respects. First, potentially strong enforcement vehicles may well be lost as a result of the pressure to settle as many cases as possible early in the process. And second, the extent to which the Commission has formalized its ADEA enforcement procedures may have limited the ability of investigators to negotiate findings of violations, since respondents may resist entering into settlement negotiations until they see whether the Commission will issue a formal letter of violation.

*Recommendation:* The Commission should determine whether its ADEA enforcement is being undermined by the reorganization and take steps to restore and renew its authority and credibility. While there is no question that the inflationary costs of litigation, coupled with budget reductions necessitate some "belt-tightening" at the Commission, neither of these considerations justifies a retrenchment of enforcement effort. The Commission needs to guard against even the appearance of such a retreat from its statutory mandate.

Accordingly, the preface to the report states:

> As the proportion of older workers in the labor force grows over the coming years, the Commission will be called upon to become ever more sensitive to the employment rights of older workers. We also believe that the Commission has a very important role to play in educating employers, unions, and employees about the need to keep older workers productive in society. This oversight report both identifies existing problem areas and recommends ways in which the Commission can improve its ADEA enforcement activity.

### 4. ADEA LEGISLATION INTRODUCED IN 1983

Several bills dealing with the ADEA were introduced in the Senate in the first session of the 98th Congress although none was enacted. These include:

S. 832, introduced by Senator Heinz and Senator Glenn, would amend the ADEA to remove the 70-year upper age limit, would allow compulsory retirement of tenured faculty until July 1, 1998, and would delay the effect of the act for employees under collective bargaining contracts until January 1, 1987, or until the contract runs out.

S. 1751, introduced by Senator Cranston, would remove the existing 70-year age limit and would abolish the exemption for those employed in executive or high policymaking positions.

S. 686, introduced by Senator Quayle, would amend the ADEA to revise enforcement procedures, would remove the 70-year age ceiling and would allow the compulsory retirement of tenured college faculty members.

S. 2167, introduced by Senator Grassley, would assure that the ADEA applies to employees who are U.S. citizens and employed in foreign workplaces that are controlled by Americans.

# Chapter 7

# SOCIAL SECURITY DISABILITY

## OVERVIEW

In 1983, the social security disability insurance (DI) program was the subject of continuing controversy and congressional attention. As in 1982, the primary area of concern stemmed from the problems associated with the Social Security Administration's (SSA) implementation of the continuing disability investigations (CDI's).

The Social Security Disability Amendments of 1980 mandated that SSA review the eligibility status of beneficiaries on the rolls at least once every 3 years, except those designated "permanently disabled," who are reviewed once every 6 or 7 years. The periodic reviews were to begin on January 1, 1982; however, on its own initiative, SSA required State agencies to begin processing CDI's in March 1981. Between March 1981 and June 1983, 946,000 case reviews were completed, and 421,000 beneficiaries were determined no longer eligible for DI benefits. In other words, 45 percent of those subject to a CDI were terminated from the rolls. The high termination rate, in conjunction with the fact that two-thirds of those who appealed to an administrative law judge (ALJ) had their benefits reinstated, led to concern that the CDI's were being administered in an improper and unjust manner.

Specifically, critics charged that the CDI's were being conducted hastily and haphazardly, and that the reviews simply did not render accurate or valid conclusions about a beneficiary's capacity to work. Though the problems with the disability review process are very complex and multifaceted, controversy has centered on four key issues: (1) The extent to which persons can be terminated whose disabling condition has not improved medically since their admittance to the rolls; (2) the manner in which medical evidence is obtained and evaluated; (3) the great discrepancy in standards of evaluation between State disability examiners and administrative law judges (ALJ's) and (4) the degree to which the mentally disabled have been discriminated against by the CDI's.

The various problems with the continuing reviews were the focus of congressional hearings held by the House Ways and Means Committee, the House Select Committee on Aging, the Senate Committee on Governmental Affairs, and the Senate Special Committee on Aging. Legislatively, numerous bills were introduced in 1983, including two comprehensive reform bills, S. 476, and H.R. 3755 (now part of H.R. 4170). However, no legislation passed both houses, other than stopgap measures to extend the provision of benefits to beneficiaries through the ALJ stage in the appeals process, a stipulation mandated by Public Law 97-455, enacted at the end of 1982.

Though Congress passed no legislation to halt the reviews, many States, on their own initiative or by court order, declared moratoria on the reviews, or began administering CDI's under guidelines that differ from SSA's official policy. At the end of the year, more than half the States were either not processing CDI's, or were doing so under modified standards. In response to public and congressional criticism, the Department of Health and Human Services (HHS) initiated a number of internal changes to improve the CDI process.

It is clear that legislative efforts to comprehensively reform the continuing eligibility review process will remain a hotly contested issue in 1984. Further, the crisis created by State moratoria on the reviews, and judicial rulings unfavorable to SSA, will have to be addressed.

## A. HISTORICAL DEVELOPMENT OF THE DISABILITY INSURANCE (DI) AND THE SUPPLEMENTAL SECURITY INCOME (SSI) PROGRAMS

### 1. The Beginning: 1954 and 1956 Amendments

To understand the concerns behind the sometimes conflicting recommendations for changes in the DI and the SSI programs, it may be helpful to review the legislative development of the programs. Although the idea for a disability program dates back to consideration of the 1935 Social Security Act, the original act and amendments through 1953 made no provision for disabled workers.

In 1954, Congress provided a disability "freeze" period similar to waiver of premiums in private life insurance contracts. Under the freeze, periods of disability would not count against a disabled worker in determining eligibility for, and the amount, of retirement benefits.

In 1956, Congress enacted a cash benefit program, 21 years after the enactment of the retirement program, and 17 years after the enactment of survivors insurance. The delay resulted, in part, from concern that providing social security disability benefits would discourage rehabilitation, encourage malingering and abuse, and add to the costs of the program—particularly during a recession when, it was argued, strong pressures would be placed on administrators to pay benefits to unemployed workers with medical impairments, regardless of their capacity for work. The so-called "liberalizing" influence of the courts in interpreting private insurance contacts, and the generally poor experience of private disability carriers during the 1930's, were cited as precedents.

There was also concern about the administrative difficulty in making disability determinations—namely, the subjectivity of determining whether a person was out of work because of a disability or for other reasons such as age, obsolete skills or experience, and the like.

In view of all of these concerns, the eligibility requirements for the cash disability program were tightly drawn in 1956 and made intentionally restrictive to guard against (1) high costs, and (2) confusion between the disability insurance program and the unemployment program.

Only those very severely disabled by a catastrophic illness or injury could qualify for benefits. A worker had to:

—Meet an age requirement—age 50 or older.

—Have substantial and recent work under social security; that is:

(1) Have *insured status for retirement benefits,* generally one quarter of coverage for each year after 1950 (or age 21 if later), up to the year of disability.

(2) Have *disability insured status,* 20 quarters (5 years) of coverage in the 40-quarter (10 years) period preceding the onset of disability.

(3) Have *currently insured status,* 6 quarters (1½ years) out of 13 quarters (3 years), before disability.

—Meet a very stringent test of disability, i.e., be unable to engage in any work by reason of a medical impairment which was expected to continue indefinitely.

—Accept vocational rehabilitation services or have benefits withheld.

—Wait 6 months following the onset of disability for payments to start.

The program was set up under a unique Federal-State relationship. The administration would be carried on by each State under contract with the Federal Government. Under agreements with the then Secretary of HEW, State disability determination units (housed within State vocational rehabilitation agencies) would make disability determinations based on the definition of disability in the Social Security Act, and in accordance with Federal regulations and guidelines issued by the Social Security Administration.

This arrangement had distinct advantages because the States had prior experience in administering various disability-related programs and had established working relationships with the medical community. It was also assumed that when the disability determination process took place within State rehabilitation agencies, disabled individuals would be more easily referred for rehabilitation. The Federal Government's primary function was to interpret the law and oversee the uniform implementation of the program throughout the country.

Program experience in the first few years was better than anticipated and the scope of the program was liberalized and substantially expanded in later years.

### 2. PROGRAM EXPANSION: 1958, 1960, AND 1965 AMENDMENTS

In 1958, benefits were added for dependents of disabled workers. The currently insured work requirement, 6 of the last 13 quarters, was also eliminated. It was brought out in congressional hearings that failure to meet the test of 20 out of 40 quarters and the 6 out of 13 quarters test—at the same time when all other disability requirements were met—resulted in 10 percent of applicants being denied.

In 1960, the age 50 requirement was dropped, making benefits payable to disabled workers of any age who met the work requirements. The 1960 Social Security Act Amendments added a 9-month trial work period—without termination of benefits—to encourage beneficiaries to return to work. They also eliminated the 6-month waiting period for those workers who reapply for disability benefits after failing in their attempts to return to work.

In 1965, Congress liberalized the definition of disability by replacing the requirement of permanent disability with a requirement that the disability must be expected to last at least 12 months or end in death. This resulted in people qualifying for benefits who might recover from their disability, in addition to those expected to remain disabled until death. The 1965 amendments tried to encourage rehabilitation efforts by permitting the use of money from the DI trust fund to reimburse State vocational rehabilitation agencies for the cost of services provided to beneficiaries. The amendments also provided for an occupational test of disability for older blind persons. While all other applicants generally must be unable to do any substantial work, older blind persons only have to be unable to engage in their former occupations.

### 3. Disability Definition Tightened: 1967 Amendments

Beginning with the enactment of the disability "freeze" in 1954, consideration had been given to both medical and vocational factors in disability determinations. Vocational factors were used to determine whether the person was able to *perform* work, rather than whether the person was able to *obtain* employment. However, SSA had not published regulations or other definitive materials to provide explicit guidance to disability examiners and ALJ's on how to apply vocational factors. This left the decision of how the factors should be weighed in the disability decision up to the courts.

Some Federal court decisions regarding vocational factors required the administration to identify jobs for which the desired applicant might have a reasonable opportunity to be hired, rather than ascertaining whether jobs exist in the economy which he can do. In 1960, only 10 percent of disability benefit awards were based on vocational factors; by 1965, awards on the basis of vocational factors were almost 16 percent of the total. Congress was concerned that judicial rulings would set standards that could lead to substantial cost overruns and that the disability program would become a form of unemployment insurance for people with physical impairments.

In 1967, Congress inserted in the statute interpretive material which was being used by the State agencies but was only in operating manuals. This language made it clear that an individual is not to be considered disabled unless his physical or mental impairments are of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience engage in any kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied. The amendments also provided for disabled widow benefits, based on medical criteria only, beginning at age 50.

## 4. SUPPLEMENTAL SECURITY INCOME (SSI) PROGRAM: 1972 AMENDMENTS

In 1972, Congress created the supplemental security income (SSI) program to replace the three State-run welfare programs for the aged, blind, and disabled. The program was intended to supplement the income of needy persons who were not covered under the social security disability program or who had earned low benefits under that program. Although most of the discussion leading up to the passage of SSI centered on serving the aged population, and the presumption was that the aged would be the largest group of such recipients, in fact, the disability portion of the program has been over 60 percent practically since the inception of the program.

TABLE 1.—NUMBER OF PERSONS INITIALLY AWARDED FEDERALLY ADMINISTERED SSI PAYMENTS, 1974–80

| | Total | Disabled | Disabled as percent of total |
|---|---|---|---|
| Period: | | | |
| 1974 | 890,768 | 387,007 | 43 |
| 1975 | 702,147 | 436,490 | 62 |
| 1976 | 542,355 | 365,822 | 67 |
| 1977 | 557,570 | 362,067 | 65 |
| 1978 | 532,447 | 348,848 | 66 |
| 1979 | 483,993 | 317,590 | 66 |
| 1980 | 496,137 | 318,699 | 64 |

Source: Social Security Administration.

Although the statutory definition of disability is the same for the SSI program as it is for the DI program, the leading causes of disability in the two programs have turned out to be quite different. More than 30 percent of awards to DI workers in 1975 (the year of the highest number of awards) were made on the basis of diseases of the circulatory system, i.e., heart disorders. The largest category of awards for the SSI adults was on the basis of mental disorders, as the following table illustrates.

TABLE 2.—COMPARISON OF DI DISABLED WORKER AWARDS AND SSI BLIND AND DISABLED ADULT AWARDS, BY DIAGNOSTIC GROUP, 1975

[In percent]

| Diagnostic group | DI | SSI |
|---|---|---|
| Infective and parasitic diseases | 1.3 | 1.6 |
| Neoplasms (cancer) | 10.0 | 5.4 |
| Endocrine, nutritional, and metabolic diseases | 4.0 | 5.0 |
| Mental disorders | 11.2 | [1] 30.7 |
| Diseases of the nervous system and sense organs | 6.8 | 10.0 |
| Diseases of the circulatory system | 30.2 | 20.7 |
| Diseases of the respiratory system | 6.6 | 4.7 |
| Diseases of the digestive system | 3.0 | 2.1 |
| Diseases of the musculoskeletal system | 18.7 | 12.7 |
| Accidents, poisonings, and violence | 5.4 | 3.9 |
| Other | 2.8 | 3.1 |
| Total | 100.0 | 100.0 |

[1] Includes mental retardation—13.1 percent

Source: U.S. Congress. Senate. Committee on Finance. Issues Related to Social Security Act Disability Programs October 1979.

## 5. Other Changes in 1972

In 1972, Congress also reduced the waiting period under the DI program from 6 to 5 months, the only change ever made to the length of the waiting period. But even more important, Congress increased disability and retirement benefits by 20 percent, and provided, effective in 1975, automatically adjusted benefits based on the rise in the Consumer Price Index (CPI). Whenever the CPI rose by 3 percent or more, benefits would rise automatically.

During the early and mid-1970's the number of recipients in both the DI program and the SSI program increased dramatically before leveling off in the late 1970's and then declining. Between 1970 and 1976, the number of disabled workers in the DI program almost doubled, from 1.5 to 2.7 million, while the covered work force increased by only 25 percent during the same period. In January 1974, about 1.3 million blind and disabled persons were brought into the SSI program from the former State welfare programs. By the end of the year, the number of SSI disability recipients had risen to 1.7 million. By December 1975, the number reached almost 2 million.

Combined DI and SSI benefit payments increased from a little over $4 billion in 1970, to about $23 billion in 1981. The following table summarizes the history of DI and SSI expenditures.

TABLE 3.—ANNUAL EXPENDITURES UNDER DI AND SSI DISABILITY PROGRAMS

[In billions]

| | DI | SSI |
|---|---|---|
| Year: | | |
| 1965 | $1.7 | [1] $0.4 |
| 1970 | 3.3 | [1] 1.0 |
| 1973 | 6.0 | [1] 1.6 |
| 1974 | 7.2 | 2.7 |
| 1975 | 8.8 | 3.1 |
| 1976 | 10.4 | 3.3 |
| 1977 | 11.9 | 3.6 |
| 1978 | 13.0 | 4.1 |
| 1979 | 14.2 | 4.3 |
| 1980 | 15.9 | 5.0 |
| 1981 | 17.7 | 5.6 |

[1] Represents expenditures under the pre-supplemental security income, State-run programs of aid to the blind and permanently disabled.

An important cost factor in the DI program is the rate at which workers become disabled and qualify for benefits. This rate is generally called the "disability incidence rate" by actuaries and demographers. The disability incidence rate remained fairly stable from 1968 to 1970, but in the next 5 years, the incidence rate increased by almost 50 percent. This increase far exceeded expectations and cannot be explained in terms of legislated changes in the disability program. Table 4 shows the number of awards and incidence rates for disabled worker beneficiaries from 1960 though 1982.

### TABLE 4.—PERSONS INSURED FOR DI AND RATES OF DISABILITY, 1960–82

| | Persons insured for DI (in millions) | Awards per 1,000 insured workers |
|---|---|---|
| Calendar year: [1] | | |
| 1960 | 46.4 | 4.5 |
| 1961 | 48.5 | 5.8 |
| 1962 | 50.5 | 5.0 |
| 1963 | 51.5 | 4.4 |
| 1964 | 52.3 | 4.0 |
| 1965 | 53.3 | 4.7 |
| 1966 | 55.0 | 5.1 |
| 1967 | 55.7 | 5.4 |
| 1968 | 56.9 | 4.8 |
| 1969 | 70.1 | 4.9 |
| 1970 | 72.4 | 4.8 |
| 1971 | 74.5 | 5.6 |
| 1972 | 76.1 | 6.0 |
| 1973 | 77.8 | 6.3 |
| 1974 | 80.4 | 6.7 |
| 1975 | 83.3 | 7.1 |
| 1976 | 85.3 | 6.5 |
| 1977 | 87.0 | 6.6 |
| 1978 | 89.4 | 5.2 |
| 1979 | 93.8 | 4.4 |
| 1980 | 95.6 | 4.1 |
| 1981 [2] | 96.8 | 3.6 |
| 1982 [2] | 98.7 | 3.0 |

[1] January 1 of each year.

[2] Preliminary.

Source: Office of Actuary, SSA, August 1983.

The adverse experience in the social security disability program in the early and mid-1970's was not an isolated phenomenon. The experiences of the State welfare programs, SSI, the civil service retirement program, and other government and privately financed disability plans were similar. The number of persons on the disability component of State welfare rolls increased greatly in the early 1970's despite declines in the low-income population. The rate of disability awards for the same period in the civil service retirement program was about twice the rate of that in the 1960's.

### TABLE 5.—DISABILITY BENEFICIARIES UNDER PUBLIC AND PRIVATE PROGRAMS

| | Disabled workers, in thousands | | | |
|---|---|---|---|---|
| | 1965 | 1970 | 1975 | 1977 |
| Programs covering long-term disability: | | | | |
| Social security disability insurance | 988 | 1,493 | 2,489 | 2,834 |
| Welfare for disabled and blind, later supplemental security income | 642 | 1,016 | 2,024 | 2,207 |
| Federal civilian employees disability | 149 | 185 | 258 | 301 |
| State and local government employees disability retirement | 69 | 86 | 128 | 152 |
| Private sector long-term disability retirement | [1] 371 | [1] 570 | [1] 825 | [1] 800 |
| Private sector long-term disability insurance | | [1] 40 | [1] 100 | [1] 110 |

[1] Figure highly approximate.

Source: President's Commission on Pension Policy, final report, appendix, Ch. 40: Disability: A comprehensive overview of programs, issues, and options for change.

A study "International Trends in Disability Program Growth" published in the October 1981 Social Security Bulletin, shows a similar spurt of growth in government disability plans in other countries. The gross disability incidence rate increased in the Belgian and Finnish programs from the late 1960's and in the programs of the Federal Republic of Germany and France in the early 1970's, tapering off by the mid-1970's.

## B. CAUSES FOR GROWTH

No studies have conclusively provided the specific reasons for the across-the-board growth in disability programs. Different analysts put more weight on one factor than another. A combination of factors is usually cited by experts on the social security program. The major factors are discussed below.

### 1. WEAK FEDERAL MANAGEMENT

A major cause of the unexpected growth in the DI program is often attributed to poor Federal administration of the program. Disability determinations are made separately by some 50 State agencies using medical and vocational standards established by the Social Security Administration. In the mid-1970's there was an enormous increase in the number of DI and SSI claims to be processed, and tremendous pressure to pay benefits timely. DI claims alone increased from about 868,000 in 1970, to about 1.3 million in 1974. DI administration was greatly deemphasized to keep pace with the escalating number of claims and at the same time to hold down administrative costs and personnel levels. Expedients were adopted in the development, documentation, and review of claims. For instance, the Social Security Administration eliminated its 100 percent review of State agency disability decisions and reviewed, instead, only a small sample of decisions. While this change resulted in reduced administrative expenses, it most likely also resulted in some disability awards which did not really meet the requirements of the law, and should have been disallowed. A preadjudicative review by the Social Security Administration that will eventually reach 65 percent of claims approved is required by the 1980 amendments.

Another problem was that the Social Security Administration had major difficulties in issuing adequate and timely criteria for determining disability. As early as 1960, the so-called Harrison subcommittee of the House Ways and Means Committee in their study of the disability program recommended that the Social Security Administration provide disability examiners and ALJ's explicit guidance in the form of regulations and other precedent materials on how to apply the vocational standards. In 1974, the House Ways and Means Committee staff also called for clear and concise regulations on vocational factors. Nevertheless, regulations were not published until 1978, 20 years after the Harrison subcommittee recommendation.

The GAO pointed out in 1976, that medical listings issued in 1968, which were being used by State agencies to justify a finding of disability, lacked specificity and failed to take into consideration advances in medical technology. GAO also commented that State agency officials complained that the listings were too time consuming or too costly to implement. SSA spent several years updating the listings, which were published in 1979.

According to a March 1981, GAO report, "More Diligent Follow-up Needed To Weed Out Ineligible SSA Disability Beneficiaries," beneficiaries who are on the rolls might never have their eligibility status reviewed and might remain on the rolls until they voluntarily return to work, reach 65, or die. Some beneficiaries were never scheduled for reexamination; others were scheduled but never reexamined. Of a 14-percent sample of disability awards in 1975, only 52 percent of the scheduled medical reexaminations were actually done. As a result of a limited followup and poor management of the disability program, GAO published a report indicating that as many as 584,000 beneficiaries who do not meet eligibility criteria might be receiving disability benefits.

### 2. MULTISTEP APPEALS PROCESS

The disability appeals process, which is essentially the same for both DI and SSI claims, can involve four distinct levels—the State agencies, the administrative law judges (ALJ's), the appeals council, and the courts. An applicant who has been denied disability benefits at the initial determination level may request a review of the claim by the State agency that made the original decision. This is referred to as a "reconsideration." The claim is reviewed by a person who did not participate in the original decision.

Those who are not satisfied with the reconsideration decision may request a hearing before an ALJ assigned to the Social Security Administration's Office of Hearing and Appeals. The ALJ may decide the case on the record or hold a hearing during which the applicant and others may present oral testimony and evidence. Applicants who disagree with the ALJ's decision may request a review by the appeals council, and independent review group also attached to the Social Security Administration Office of Hearings and Appeals. The appeals council may deny or grant a request for review.

If the council upholds the ALJ decision or refuses to review the case, the applicant may request a judicial review in a U.S. district court. The district court's decision is appealable to the appropriate U.S. circuit court, and the case may even end up in the Supreme Court.

## CHART 1

## DISABILITY DECISIONMAKING

| | Administered by: | Time allowed to request next stage | Average time from request to decision[1] |
|---|---|---|---|
| INITIAL CLAIM | SSA District Office | 60 days | 65 days |
| RECONSIDERATION | State Agency (DDS)* | 60 days | 50 days |
| HEARING | SSA's Administrative Law Judges | 60 days | 184 days[2] |
| APPEAL | SSA's Appeals Council | 60 days | 80 days[2] |
| FEDERAL COURT REVIEW | Federal Court System | -- | N.A. |

---

*Disability Determination Service.

[1] May 1983.

[2] Estimate; includes appeals of both initial denials and CDI terminations.

The number of cases reversed on appeal has been increasing, with most of the increase occurring at the ALJ level. In 1964, about 10 percent of all allowances resulted from appeals beyond a denial at the first level. This percentage has risen steadily and tripled by 1980.

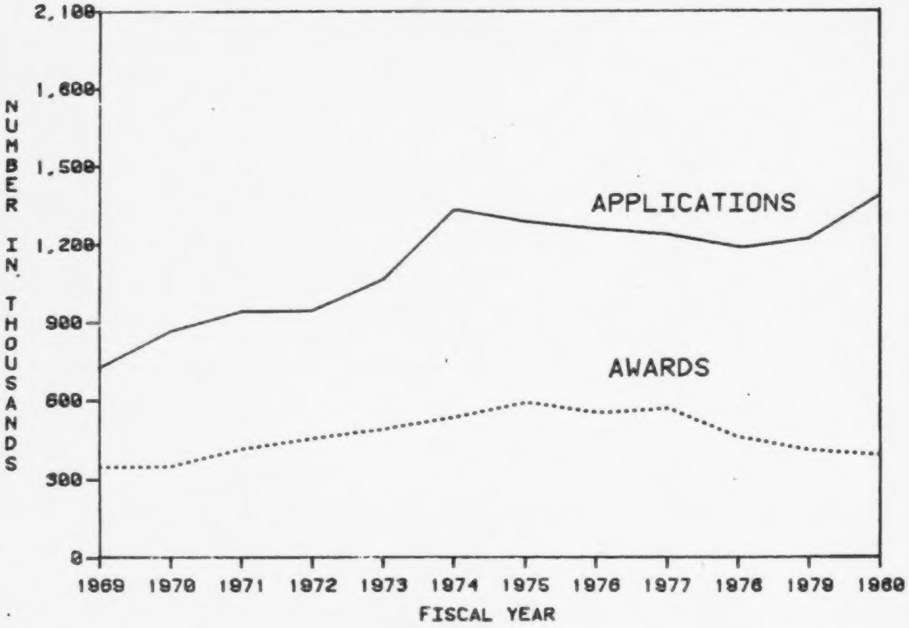
TABLE 6.—TOTAL DI ALLOWANCES: 1964, 1980

| | 1964 | | 1980 | |
|---|---|---|---|---|
| | Number of awards | Percent of total | Number of awards | Percent of total |
| State agency: | | | | |
| Initial | 190,000 | 90.0 | 253,000 | 69.5 |
| Reconsideration | 15,000 | 7.5 | 32,000 | 9.4 |
| Administrative law judge hearings | 5,000 | 2.5 | 66,000 | 21.0 |

Source: Social Security Administration.

## CHART 2

## DISABLED WORKER APPLICATIONS AND AWARDS 1969-1980



SOURCE: SOCIAL SECURITY ADMINISTRATION

### 3. Social Acceptance of Disability

Workers of all ages are more frequently claiming they are disabled and are more often being awarded benefits than in previous years. This tendency occurs across all educational levels. Medical evidence, however, shows no increase in impairments.

TABLE 7.—SELF-REPORTED INABILITY TO PERFORM USUAL MAJOR ACTIVITY AMONG MEN, AGE 45 TO 64

[In percent]

| | Did not complete high school | High school graduate | More than high school |
|---|---|---|---|
| Year: | | | |
| 1969 | 10.6 | 4.0 | 2.8 |
| 1974 | 15.1 | 5.4 | 3.5 |
| 1978 | 17.1 | 7.4 | 3.9 |

Source: National Center for Health Statistics.

Disability is not, however, solely a medical phenomenon. There is no one-to-one correspondence between an impairment and a disability. An impairment is a physical or mental abnormality determined by a physician, such as a loss of limbs, or poor hearing. Disability—the social concept—is an inability to earn a living which may result from an impairment. The determination of whether an impairment constitutes a disability for a particular person is a matter of judgment based on nonmedical factors such as age, education, skills, experience, motivation, and the alternatives available.

### 4. GREATER AWARENESS OF THE DI PROGRAM

Data from the 1972 Survey of the Disabled show that, more than 15 years after the establishment of the DI program, almost one-half of the people who could not work regularly or work at all were unaware of the existence of the disability program. The SSI program was successful in spreading public knowledge of disability benefits because the SSI program is administered by the Social Security Administration. When people applied for the new SSI program, many were found to be also entitled to DI benefits based on their wage record. The number of people applying for disability benefits peaked in 1974—the first year of the SSI program.

### 5. HIGH BENEFIT LEVELS

DI benefit levels rose rapidly after 1969, both in absolute terms and as a percentage of predisability earnings. In 1970-75, there were six benefit increases, for a compounded effect of an 82-percent increase. According to SSA actuaries, 28 percent of new disability entitlements during the 1969-75 period had disability benefits that exceeded 80 percent of predisability earnings.

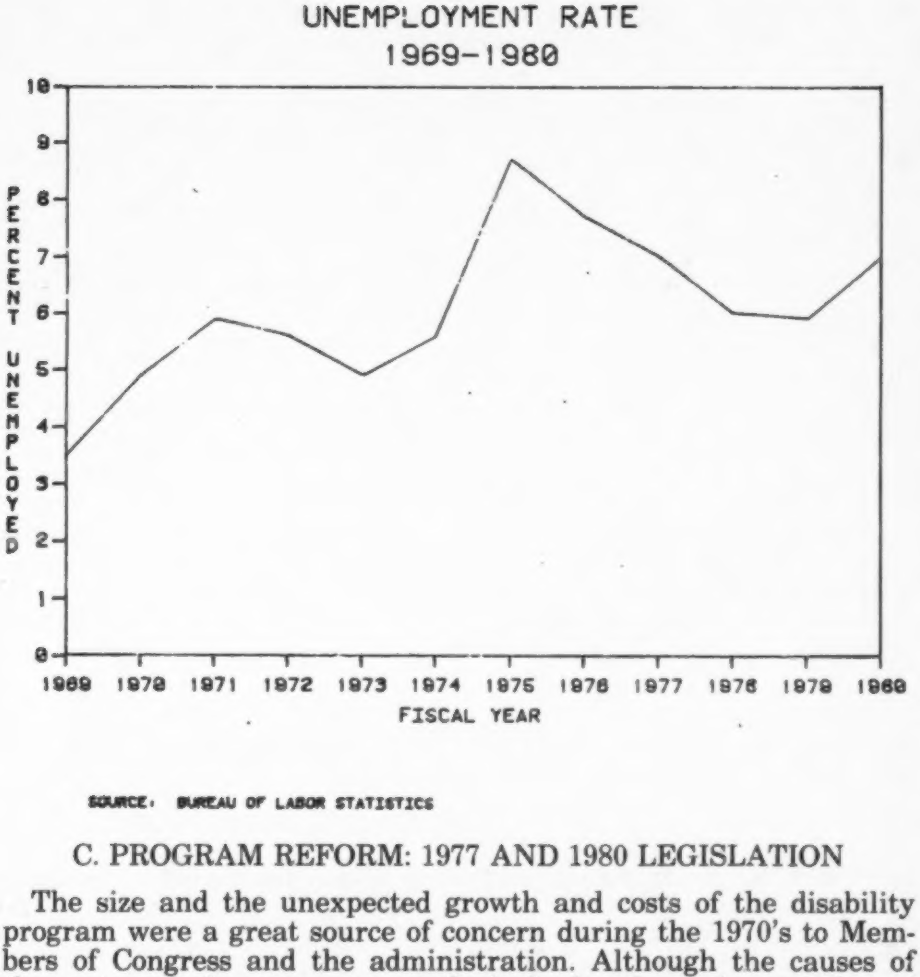
Some experts suggest that high replacement rates attract disabled people onto the rolls and may discourage those already on the rolls from returning to work.

### 6. POOR ECONOMIC CONDITIONS

When unemployment is high, it is harder for disabled workers to find and to keep jobs, so workers are more likely to apply for, and pursue disability benefits. For several years before 1970, the unemployment rate remained stable at below 4 percent. Since 1970, unemployed people have made up more than 5 percent of the labor force in every year except 1973 (4.9 percent). As chart 2 indicates, the year of the highest number of disability applications and awards was in the 1974-75 period when the unemployment rate was increasing, reaching 8.5 percent in 1975. (See chart 3.)

A research article "Disability Benefit Applications and the Economy," published in the March 1979 Social Security Bulletin, further indicates that the effect of labor market conditions need not be symmetrical—that is, more people tend to be pushed on the rolls by a deteriorating labor market than tend to be pulled off by improving labor market conditions. Thus, a large increase in unemployment—such as the increase experienced in 1975—may lead to a permanent upward shift in the number of beneficiaries on the disability rolls. The SSA report estimates that 19 percent of the applications received during 1970-78 may have resulted from changes in the economic choices facing disabled persons.

CHART 3



SOURCE: BUREAU OF LABOR STATISTICS

## C. PROGRAM REFORM: 1977 AND 1980 LEGISLATION

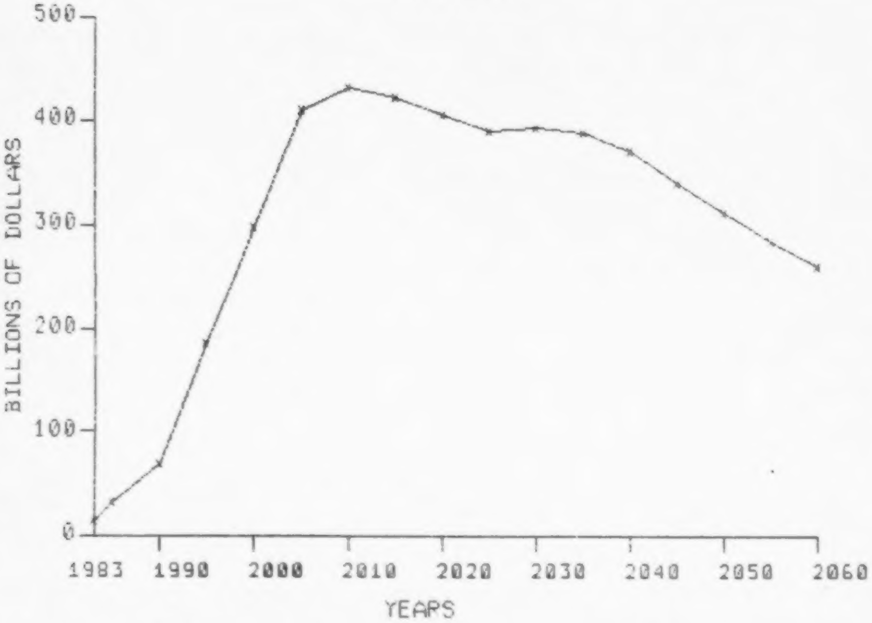
The size and the unexpected growth and costs of the disability program were a great source of concern during the 1970's to Members of Congress and the administration. Although the causes of the cost explosion were not conclusively documented, a number of legislative changes were implemented to increase revenues to the program and to control expenditures.

### 1. 1977 Amendments

In 1977, Congress substantially strengthened the financial condition of the OASI and the DI trust funds by legislating payroll tax increases, and lowering future costs by changing the indexing formula. By some estimates, newly awarded DI benefits following the 1977 amendments were about 10 percent lower, on average, than those previously payable. Benefits for younger workers, where relatively higher benefit amounts had been more prevalent, were lowered even more. Whereas the DI trust fund has been projected to become exhausted in late 1978 or 1979 before the 1977 changes, the fund is now projected to remain solvent over the next 75 years as shown in the following chart.

CHART 4

DISABILITY INSURANCE
LONG RANGE FORECASTS OF TRUST FUND RESERVES
1983-2060



Source: 1983 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds. Assumption II-B.

## 2. 1980 AMENDMENTS

In 1980, Congress passed disability reform legislation that had been developing since 1974. The legislation grew out of concerns that work disincentives in the system, combined with faulty administration, might be responsible for the rapid growth in the program. The 1980 amendments set out to enhance work incentives in the DI and SSI programs and to improve the administration of the program to insure that benefits are only paid to those who are eligible. The 1981 trustees report projects disability recovery rates in the DI program will be 20 percent higher because of these amendments.

Major administrative provisions of the 1980 amendments require the Secretary of Health and Human Services to:

—Issue regulations specifying performance standards along with administrative requirements and the procedures to be followed by the States in performing the disability determination function.

—Review a specified percentage of claims approved by the State agencies before benefits are paid.

—Review decisions rendered by administrative law judges in disability cases and report to the Congress by January 1982, on the progress of this effort.

—Conduct experiments and demonstrations to test the effectiveness of various ways of encouraging the disabled to return to work.

The 1980 amendments also require the Social Security Administration, beginning in 1982, to review the cases of disabled workers on the DI rolls at least once every 3 years, except where the disability is considered permanent. SSA has accelerated this review, due to GAO and SSA reports released in 1981, indicating that many current beneficiaries, perhaps 20 percent, may not be disabled.

Although no changes were made in the definition of disability in House consideration of the 1980 legislation, a proposed amendment was narrowly defeated by the full House Ways and Means Committee, which would have eliminated vocational factors in disability determinations. Eligibility would have been based solely on the person's medical condition. One reason for continuing present law rules was that the number of disability awards, based on vocational factors, declined from a high of 27 percent in 1975, to only 22 percent in 1979.

Congress was also concerned about excessive replacement rates (the ratio of benefits to earnings), where dependents' benefits are involved, and it passed a provision to cap family benefits to insure that no one will receive more in benefits that he or she had previously been earning. Even after imposing this new limit on DI family benefits, Congress remained concerned about excessive replacement rates. Multiple benefits, when a worker receives benefits from a number of different programs, may mean excessive earnings replacement rates and disincentives to work. A Social Security Administration study found that in 1971, 44 percent of workers who had been disabled for a year or more also received benefits from other public or private programs, in addition to disability benefits. Such multiple benefits may raise earnings replacement rates above those obtained when the computation is limited to social security disability benefits alone. Consequently, Congress enacted a provision in the Omnibus Reconciliation Act of 1981, placing a cap on the amount of disability benefits received from Federal, State, and local government plans, so that combined benefits do not exceed previous earnings. Other changes recommended by the Reagan administration were not adopted in 1981 or 1982.

## D. THE CURRENT PROGRAM

In 1983, there were 3.9 million DI beneficiaries (2.6 million of whom were disabled workers). The average benefit for single disabled workers was $441 a month; $841 per month for disabled workers with dependents. Fiscal year 1983 expenditures on the DI program were just under $18 billion.

Families of older workers are the primary beneficiaries of DI benefits: 50 percent of disabled workers are between the ages of 55 and 64, and 73 percent of all disabled workers are age 50 to 64. (At age 65, all disability awards are converted to retirement benefits automatically).

### 1. Present Disability Definition

Legislatively, disability is defined as the inability to engage in any kind of substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment which can result in death or be expected to last for a continuous period of not less than 12 months. One must not only be unable to do one's previous work but also, considering age, education, and work experience, engage in any kind of substantial gainful activity which exists in the national economy (i.e., in significant numbers in the region where one lives, or in several regions in the country). It is immaterial whether such work exists in the immediate area where the applicant lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work.

The statutory definition of disability is the same for the SSI program, and it is considered to be a strict definition, which only the most severely disabled can meet. It is designed to distinguish between those who are out of work because of their medically determinable impairment and those who are out of work for other reasons. However, the statute is not specific in describing how the definition is to be applied in individual cases. This is spelled out in regulations and operating instructions.

### 2. Disability Decision Process

It is not possible to evaluate each applicant on all of the objective and subjective factors that enter into determining inability to work. To process more than a million new claims each year, a five-step sequential evaluation procedure has been established. When a determination can be made at any step, evaluation under a subsequent step is unnecessary.

(1) The first step in the evaluation is to determine whether the applicant is currently engaging in substantial gainful activity (SGA). Under present regulations, if a person is actually earning $300 a month, he or she is engaging in SGA and is considered not disabled. Earnings are a clear sign that the person is able to work. Medical, vocational, or other factors are not explored.

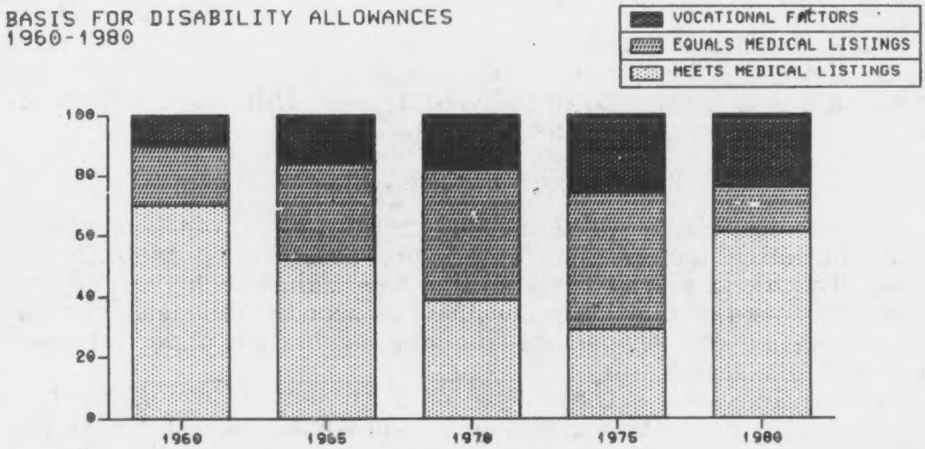
(2) The second step in the sequence is to determine whether the applicant has a "severe" impairment. A "severe" impairment is defined as one that significantly limits physical and/or mental capacities to perform basic work-related functions. It is determined by medically acceptable clinical and laboratory diagnostic techniques. No consideration is given to a person's past work or other vocational factors. If the applicant does not have an impairment that is considered severe, the claim is denied at this point.

(3) If the applicant does have a severe impairment the next step is to determine whether the impairment meets or equals one of the disabling conditions specified in the medical listings developed by the Social Security Administration. If the impairment meets the duration requirements (1 year) and is included in, or equivalent to, the medical listings, the applicant is presumed to be disabled without consideration of vocational factors.

(4) In cases where a finding of disability, or of no "disability," cannot be based on the SGA test, or on medical consideration alone, but the person does have a severe impairment, the fourth step is to evaluate the individual's "residual functional capacity" (RFC) and the physical and mental demands of past work. If the impairment does not prevent the applicant from performing past work, there must be a decision that the person is not disabled. If the applicant cannot carry out his former occupation, vocational factors come into play.

(5) The final step in the sequence is consideration of whether the applicant's impairment prevents other work. At this stage, the burden of proof shifts to the Government to show that the applicant can, considering his impairment, age, education, and work experience, engage in some other kind of work which exists in the national economy. Such work, however, does not have to exist in the immediate area in which an applicant lives; and a specific job vacancy does not have to be available.

CHART 5



Source: Social Security Administration

## E. THE CONTINUING DISABILITY INVESTIGATIONS

As mentioned earlier, the 1980 amendments to the Social Security Act mandated critical changes in the disability program. These changes were intended to curb the rapid expansion in the program experienced in the mid-1970's, and to encourage beneficiaries to return to work. A key provision in the legislation was the requirement that SSA review the continuing eligibility of beneficiaries at least once every 3 years, except for the "permanently" disabled, who are to be reviewed at an interval determined by the Secretary of HHS (currently once every 6 or 7 years). The new law did not provide SSA with any new administrative authority. Since the inception of the program, SSA had the responsibility of continuously monitoring the eligibility of beneficiaries on the rolls. The 1980 amendments simply established a minimum review requirement.

It should be noted that this periodic review provision was not expected to yield significant savings until 1984. The CDI's were intended to begin on January 1, 1982, with their implementation producing a net savings of only $10 million in the 4-year period between 1982 and 1985.[1]

A General Accounting Office (GAO) report issued in January 1981, estimated that as many as 20 percent, or 584,000, of the beneficiaries on the DI rolls were either ineligible or receiving too large a benefit payment.[2] The report claimed that SSA's management of the DI program was deficient, and in particular, that SSA's procedures for reviewing the disability status of individuals who were likely to have improved were seriously flawed. Most individuals never had their eligibility reviewed; and of those that met the criteria for reexamination, most were never actually rereviewed. GAO, after examining this record of poor management, recommended that SSA improve the effectiveness of the review process, and expedite the CDI's.

On its own initiative, SSA accelerated the implementation of the reviews scheduled to begin January 1, 1982 to March 1981. SSA witnesses at congressional hearings repeatedly cited the GAO report, and congressional pressure (as witnessed in the 1980 amendments) as justification for this acceleration. However, it should be noted that this decision was strongly influenced, if not determined, by Office of Management and Budget directives to produce additional savings in the DI program.

The accelerated reviews were included as part of the Reagan administration's fiscal year 1982 budget initiatives, and involved reviewing 30,000 additional DI cases per month beyond the regular review workload. In fiscal year 1980, SSA reviewed the continuing eligibility of 160,000 beneficiaries; in fiscal year 1981, close to 260,000 CDI's were conducted. Once initiated, the volume of the CDI's increased dramatically. Overall, between March 1981 and June 1983, 946,000 case reviews were completed, and 421,000 beneficiaries were determined no longer eligible for DI benefits.

TABLE 8.—CONTINUING DISABILITY INVESTIGATIONS: SUMMARY DATA MARCH 1981 THROUGH JUNE 1983

[DI and SSI cases]

| Period | Initial State agency decisions | | | |
|---|---|---|---|---|
| | Total cases reviewed | Total decisions made | Continuances | Terminations |
| March 1981 to September 1981 | 180,000 | 146,000 | 76,000 | 70,000 |
| October 1981 to September 1982 | 497,000 | 435,000 | 240,000 | 195,000 |
| October 1982 to June 1983 [1] | 457,000 | 365,000 | 208,000 | 156,000 |
| Total | 1,134,000 | 946,000 | 524,000 | 421,000 |

[1] Preliminary data.

Source: U.S. Congress. Senate. Finance Committee. Committee print 98–93. 98th Cong., 1st Sess. Washington, U.S. Govt. Print. Off., September 1983.

---

[1] U.S. Congress. House. Committee on Ways and Means. Subcommittee on Social Security. Status of the Disability Insurance Program. Report prepared by the staff of the Subcommittee on Social Security. Ways and Means committee print (WMCP): 97–3, 97th Cong., 1st Sess., Mar. 16, 1981. Washington, U.S. Govt. Print. Off., 1981.

[2] U.S. General Accounting Office. More Diligent Followup Needed To Weed Out Ineligible SSA Disability Beneficiaries. Report to the Congress by the Comptroller General of the United States. HRD–81–48, Mar. 3, 1981. Washington, 1981.

Not long after the CDI's were implemented in March 1981, congressional concern arose about the quality, accuracy, and fairness of the reviews. Press accounts of severely disabled individuals who had been terminated from the rolls began to proliferate; and constituent reports to Members of Congress established an alarming pattern of questionable terminations. It became clear that close to half of all DI beneficiaries subjected to a CDI were terminated at the initial decision level, often without much warning, and in many instances with much evidence that the individual was not disabled. Significantly, 65 percent of those terminated had their benefits reinstated, if they appealed to an administrative law judge.

### 1. Congressional Response to the CDI's

In 1982 and 1983, a great number of legislative proposals were introduced to address various problems associated with the CDI's. Perhaps the most significant measure, H.R. 3755, was reported out of the House Ways and Means Committee on September 27, 1983. The committee subsequently incorporated them into the Tax Reform Act of 1983, H.R. 4170, which entails a wide variety of tax law revisions, as well as measures related to medicare, medicaid, and trade adjustment assistance. The bill was never brought to the floor in 1983. The major disability provisions in the legislation are:

—Permanent authority for continued benefit payments through the ALJ decision in cases where a termination of benefits for medical reasons is being appealed (this authority expired under current law on December 7, 1983).

—For a temporary delay of reviews of all mental impairment disabilities until regulations stipulating new medical listings for mental impairments are published, which must be no later than April 1, 1984. This moratorium would include all cases upon which a timely appeal was pending on or after June 7, 1983, and the bill provides special procedures for any new mental impairment applications denied during this period and for those with mental disabilities who had had benefits terminated after March 1, 1981.

—That benefit payments be continued for those under review whose medical condition has not improved unless the individual is working at the substantial gainful activity level, the original determination was in error or obtained by fraud, the individual had benefited from advances in medical technology or vocational therapy, or new evidence (including that arising from new diagnostic techniques) shows the impairment to be less severe than originally thought.

—That in cases of multiple impairments, the combined effect of all the impairments must be considered in making disability determinations.

—That a face-to-face hearing between the beneficiary and State agency disability examiners would be held in potential termination cases at the initial decision level, and that demonstration projects be held in five States on initial level face-to-face meetings for all unfavorable decisions (which include those rendered to new claimants) with a report to Congress by April 1, 1985.

—That a psychiatrist or psychologist must complete the evaluations of individuals with mental disabilities in unfavorable decisions.

—That all disability decisionmakers within the system (SSA and the States) are bound only by policy set out in regulation.

—That SSA must apply Federal circuit court decisions uniformly in that circuit, unless they are appealed.

—For more flexible reimbursement provisions to providers of vocational rehabilitation services.

—For a study to be done by the National Academy of Sciences by January 1, 1985, on using subjective evidence of pain in the disability determination process; and

—For the establishment of an Advisory Council on Medical Aspects of Disability.

On the Senate side, a comprehensive bill was introduced on February 15, 1983, by Senator Levin. It was referred to the Senate Finance Committee, which has yet to hold markup sessions on the bill. The major provisions of S. 476 are:

—SSA would have to show that the beneficiary has medically improved so as to be significantly more capable or performing substantial gainful employment, before the beneficiary could be terminated, unless the person has been actually working or was put on or continued in error, or new tests demonstrate that the disability is not as severe as originally thought.

—SSA would be required to develop a complete medical history of the beneficiary for the last 12 months and made every reasonable effort to obtain the necessary information from the treating physician.

—Each beneficiary would be entitled to a face-to-face interview with the State disability examiner before the decision to terminate is made.

—Each beneficiary terminated by the State disability examiner would have the right to an immediate appeal to an administrative law judge. This would eliminate the current procedures for a reconsideration at the State level.

—Payment of benefits would continue through appeal to the ALJ.

—SSA would be required to appeal any decision from a circuit court of appeals to which it has chosen not to acquiesce.

—Uniform standards for determining disability or recovery from disability would be required at all levels of the review process and would be promulgated as regulations which are made subject to notice and comment.

—SSA would be required to provide comprehensive and timely notice to beneficiaries of their rights under the law and each of SSA's decisions made in the review process, including notice of termination, and notice to review the State decision or the ALJ decision.

On November 17, 1983, Senators Levin and Cohen attempted to include as an amendment to H.R. 3959 (a supplemental appropriations bill) a compromise package that was considerably less costly than either S. 476 or H.R. 4170. The amendment was tabled by a vote of 49 to 46.

The major way in which the amendment differs from S. 476 is in its inclusion of a "prior work" exception to the medical improvement standard. Essentially, this exception would allow SSA to terminate beneficiaries for whom there has been no medical improvement, but nonetheless that individual is capable of performing in his or her previous employment. Critics of this exception argue that it would provide a serious loophole through which SSA could implement arbitrary policies.

Throughout 1983, scores of congressional hearings were held, covering a wide range of issues related to the implementation of Social Security Disability Amendments of 1980. Overall, congressional attention has focused on a number of key issues, which are discussed below.

### (A) MEDICAL IMPROVEMENT

One of the first problems cited with CDI's was the fact that beneficiaries were being terminated from the rolls despite the fact that their disabling condition had not improved, or had worsened. In essence, beneficiaries admitted to the rolls under one set of standards were being reevaluated upon a new, more stringent set of standards, and many were being terminated. People who had been placed on the DI rolls 5, 10, and 15 years before the CDI's, many of whom had been led to believe they had been granted a lifetime disability pension, were removed from the rolls with little advance warning or explanation.

The central issue in the debate surrounding the concept of medical improvement is the question of who must bear the burden of proof in the determination of continuing eligibility for DI benefits. Currently, it is the obligation of the beneficiary to prove during the course of a CDI that his or her disability meets contemporary eligibility criteria. How long that person has been on the rolls, or whether or not that person is physically or mentally more fit for employment than when first granted disability status, is immaterial. SSA is obligated only to evaluate cases in relation to present day medical and vocational standards. With a medical improvement standard, the burden of proof shifts from the beneficiary to SSA, and it becomes the obligation of the agency to demonstrate that the individual's disabling condition has improved.

The issue of medical improvement is understood best when considered within the appropriate historical context. As mentioned earlier, the mid-1970's was a period marked by rapid program expansion, liberal eligibility standards, and high allowance rates for claimants applying for DI benefits. Many of those admitted to the rolls were allowed by virtue of a lenient and favorable "adjudicative climate," and given the inherent flexibility and subjectivity of the disability decisionmaking process, such intangible factors can be very important.

In the late 1970's and early 1980's, eligibility standards became stricter, allowance rates plummeted, and the adjudicative climate became more rigid. The CDI's, which operate under current standards, are being applied to cases that were determined in the earlier period, and hence it is frequently the case that someone admitted to the rolls in the mid-1970's is suddenly terminated because that person's disability does not match the current standards.

Both comprehensive bills currently pending before Congress, H.R. 4170 and S. 476, include a stipulation that in reviewing continuing eligibility, SSA must employ a medical improvement standard. In both these bills, SSA is required to demonstrate a beneficiary's condition has improved, or that one of four exceptions apply. The exceptions are: (1) That the individual is actually working, and hence should no longer be eligible; (2) the original admittance decision was clearly erroneous or fraudulent; (3) the individual has benefited from advances in medical or vocational technology that allows him to work; and (4) new evaluational techniques show that the disabling impairment is not as severe as originally thought.

### (B) UNIFORM STANDARDS

One of the critical problems in the disability review process is that different levels of review are bound to different evaluational criteria. The fact that ALJ's reverse almost two-thirds of all appeals of State agency termination decisions is the most striking indication of this structural flaw.

Currently, SSA issues many substantive policy changes through subregulatory means, such as the POMS (operating procedures), internal memoranda, and Social Security rulings. These changes are not open to public comment and review. To the extent that there are ambiguities or substantive conflicts between these subregulatory standards and published Federal regulations, State disability examiners are bound to SSA's administrative directives, while ALJ's adjudicate on the basis of formal regulations.

The root of this inconsistency lies in the statutory exclusion of SSA from the rulemaking requirements defined in the Administrative Procedures Act (APA) of 1946. The APA requires that if an agency intends to propose rulemaking changes, it must publish those proposals in the Federal Register and allow public comment and review. Agencies are allowed to use internal, subregulatory channels to disseminate instructions that serve to clarify or provide interpretive assistance in the concrete administration of the rules. Although HHS has voluntarily agreed to follow APA guidelines, SSA nonetheless continues to promulgate substantive policy changes through subregulatory methods without ever allowing public inspection. The upshot of this practice is that there is no uniformity throughout the disability review and appeals process.

Both comprehensive bills include provisions mandating that SSA follow the public notice and comment requirements of the APA. Advocates claim this would insure uniform standards at all levels of adjudication, and would allow greater public participation in the rulemaking process.

### (C) MENTAL IMPAIRMENTS

One of the most heavily criticized aspects of the CDI's is that the reviews systematically discriminate against mentally disabled beneficiaries. Overwhelming evidence presented at a Senate Special Committee on Aging hearing in April 1983, showed the mentally impaired were among the most likely to be reviewed, and the most likely to be terminated, of the beneficiary population.

On the first day of hearings, a wide variety of witnesses testified to the serious problems in the reviews of the mentally disabled. Witnesses documented again and again the fact that SSA was terminating from the rolls beneficiaries clearly unable to work. Since the evaluation of mental impairments is often subjective, and based on symptomological evidence, it was very easy for SSA to terminate people with mental disabilities. The relevant medical listings are antiquated, and SSA instituted an extraordinarily rigid policy in evaluating the RFC of mentally impaired individuals.

A GAO report presented at the hearing documented that SSA implemented particularly stringent review standards for the mentally impaired, and that these guidelines were deeply flawed. GAO also reported that State agency disability determination services were not sufficiently staffed with qualified psychiatrists or psychologists, and hence medical evaluations of the mentally disabled are being conducted by general practitioners unqualified to render valid decisions.

The GAO report demonstrated that although only 11 percent of those on the rolls are there because of mental impairments, 27 percent of those terminated by the CDI's are of the mentally disabled category. Further, ALJ reversal rates for mental disability appeals cases are much higher proportionally (91 percent) than for the rest of the disabled population.

In response to the evidence presented at this hearing, Senator Heinz introduced S. 1144, a bill to impose a temporary moratorium upon the reviews of the mentally disabled, pending revision of the regulatory criteria relating to the review of mental impairments. This revision would be completed by SSA in a period of 6 months, in consultation with a panel of experts in the field of mental health. The bill also includes a provision requiring that only a qualified psychologist or psychiatrist make the medical determination in mental impairment cases.

On June 15, 1983, Senator Heinz offered an amendment to a supplemental appropriations bill (H.R. 3069) that contained the basic provisions in S. 1144. The amendment passed the Senate by a wide margin, but was dropped in the House-Senate conference due to a procedural conflict with House rules that preclude the addition of substantive authorizing legislation to appropriations bills.

Subsequently, the major provisions of S. 1144 were incorporated into H.R. 4170, the House bill to comprehensively reform the disability review process.

### (D) QUALITY OF THE CDI'S

Not long after the CDI's were first implemented, it became clear that there were serious inadequacies in the review process. Without sufficient time, staffing, or resources, State agencies were forced to process far too many CDI's, far too quickly. Further, the manner in which the cases were developed, including the collection of medical evidence, came into serious question.

The simple increase in volume from a routine 160,000 reviews per year to roughly 500,000 CDI's in fiscal year 1983, in and of itself accounts for a major dimension of this problem. The phase-in period was much more rapid than intended by Congress, and State agencies sacrificed thoroughness and accuracy to speed and efficiency.

Legislation enacted at the end of 1982 addressed, to a certain degree, the problems associated with volume. Public Law 97-455 (H.R. 7093) provided the Secretary of HHS the authority to waiver, on a State-by-State basis, the requirement that all nonpermanently disabled beneficiaries be subject to a CDI at least once every 3 years. This waiver authority allowed SSA to decrease the volume of reviews, and thereby improve their administration.

Another problem cited with the CDI's was their impersonal, paper-oriented character. CDI's were conducted without the benefit of any face-to-face interaction between the beneficiary and the disability examiners. Before the ALJ stage, determinations were based strictly on written evidence.

Public Law 97-455 addressed this problem, to a limited extent. The legislation required that SSA begin administering face-to-face evidentiary hearings at the reconsideration level. Many argue that this is insufficient, and both S. 476 and H.R. 4170 require SSA to implement face-to-face hearings at the initial decision level.

Public Law 97-455 also included a provision requiring SSA to notify all terminated beneficiaries of the procedures employed in reconsideration decisions, including the right to introduce evidence and to be represented by an attorney. This requirement addressed one aspect of the entire problem of properly notifying beneficiaries about what a CDI entails, what is expected of them, and what the range of potential outcomes from the CDI might be.

### (E) OTHER ISSUES

A key issue that has been involved with the controversy surrounding the continuing eligibility review process is the extension of benefits through the ALJ stage to beneficiaries choosing to appeal State agency termination decisions.

Public Law 97-455 included a provision extending benefits through the ALJ stage, subject to recoupment in the event that the ALJ sustains the termination decision. This provision, however, was adopted on a temporary basis only, pending further congressional action to comprehensively reform the disability review process. "Aid-paid-pending" was due to expire in October 1983; however, Congress enacted a 67-day extension as part of H.R. 4101. That extension expired in December, and unless Congress acts before April 1984, extended benefits will cease.

Another issue of interest to Congress is the role the combined effect of multiple impairments should play in the disability determination process. Presently, if an individual has several impairments, none of which on their own constitute a severe impairment, that individual is disqualified at the first level in the sequential evaluation (i.e., the test of a severe or nonsevere impairment). H.R. 4170 includes a provision requiring SSA to evaluate the combined effect of all the individual's impairments, regardless of the severity of any individual impairment evaluated on its own.

## 2. ADMINISTRATIVE ACTIONS

In response to congressional pressure and public outcry, the Social Security Administration has implemented a number of its own initiatives to address the problems associated with the disability determination process in general, and CDI's in particular. These initiatives were instituted in two waves; one in late 1982; another in June 1983.

In 1982, SSA began conducting face-to-face informational interviews at SSA district offices to obtain directly from beneficiaries pertinent medical records. The definition of "permanently disabled" was expanded to include additional impairments, and thereby exclude from the CDI's certain groups of beneficiaries. SSA began requiring State disability determination services to collect all relevant medical evidence for the previous 12 months in order to improve the medical evaluation and case development procedures. State agencies are also now required to be more thorough and specific in delineating why beneficiaries are no longer eligible for disability benefits. SSA also initiated a project to reexamine the evaluational process employed in reviewing mental disorders, including testing the utility of multiple consultative examinations in psychiatric cases. Finally, SSA reduced the volume of CDI's in a limited number of States.

In response to many of the problems brought to light by the April Senate Aging Committee's hearing on "Social Security Review of the Mentally Disabled," Secretary Heckler announced a series of administrative initiatives on June 7, 1983. These initiatives included a moratoria on reviews of two-thirds (135,000) of all mental impairment cases, pending consultation with mental health specialists on methods to revise and improve the review process for those with mental disorders. Additionally, another 200,000 beneficiaries were designated "permanently disabled," which raised the total exempt from the CDI's to 37 percent of all those on the rolls. SSA also instituted a policy of random selection of CDI cases (rather than focusing on targeted groups most likely to generate terminations), thereby lowering the termination rate.

## 3. STATE ACTIONS

A great number of States have revolted against SSA's recent practices and policies relating to the CDI's, and many Governors and State agency administrators have imposed moratoria on the reviews. On March 8, Massachusetts Governor Dukakis issued an executive order requiring the State disability determination office to implement a medical improvement standard in reviewing cases, as ordered by a district judge in *Miranda* v. *Secretary of HHS.* Arkansas, Kansas, and West Virginia have similarly implemented review procedures at odds with official SSA policy. In Kansas, Governor Carlin also ordered the reopening and reexamination of all cases terminated since March 1981.

On July 22, 1983, Cesar Perales, commissioner of the New York State Department of Social Services, suspended reviews pending the establishment of a medical improvement standard. Alabama, New Jersey Pennsylvania, Michigan, Maine, Illinois, Virginia, North Carolina, and New Mexico all have self-initiated moratoria on the reviews. Alaska, Arizona, California, Hawaii, Idaho, Montana, Nevada, Oregon, and Washington have now or at one time initiated temporary or indefinate moratoria. Combined, more that half the States, at the end of 1983, were either not processing the reviews, or were conducting them under standards that varied with official SSA procedures and requirements.

### 4. Judicial Rulings

As CDI terminations mounted, thousands of individuals appealed their cases to the Federal courts. The subsequent court decisions have very frequently ruled that SSA's policies and procedures violate the law. A number of Federal courts have ruled SSA must employ a medical improvement standard when conducting CDI's. Two courts have determined that SSA's reviews of the mentally ill have been administered in an "arbitrary and illegal" fashion. These legal actions have contributed to the disintegration of national uniformity in the disability program.

#### (A) MEDICAL IMPROVEMENT

Currently, SSA does not use medical improvement as a standard for evaluating the continuing eligibility of disability beneficiaries. However, a number of Federal courts have ruled that this policy is in violation of the law, and that SSA must demonstrate either that an individual has improved medically while on the rolls, or that the original decision was clearly erroneous before terminating benefits. This has been the position of the courts in SSI, SSI "grandfathered," and DI cases. Other courts have ruled that once a person has been found disabled, there is a presumption that the individual remains disabled and that SSA bears the burden of proof in determining that beneficiary is no longer disabled.

The Ninth Circuit Court of Appeals has ruled in two cases—*Finnegan* v. *Mathews* and *Patti* v. *Schweiker* that SSA must incorporate a medical improvement standard into its administration of the CDI's. Courts in virtually every other circuit have since rendered medical improvement decisions unfavorable to SSA.

#### (B) NONACQUIESCENCE

Under the Federal judicial system, decisions of a circuit court of appeals are considered the "law of the circuit" and constitute binding case law on all district courts within the circuit. SSA's policy with regard to rulings with which it disagrees has been to apply the unfavorable decision only to the specific case upon which it was rendered, and not to the entire circuit, or to the rest of the Nation. Hence, the interpretation of the law by the court is not considered binding for either State agency disability determination services or for Federal SSA offices. SSA also instructs its ALJ's to persist in applying existing agency policy and ignore the court's rulings.

This policy, in combination with SSA's refusal to appeal any unfavorable circuit court decisions to the Supreme Court (which would determine a national standard) has been heavily criticized as arrogant and lawless behavior on the part of a Federal agency. Federal judges in both the eighth and ninth circuits have challenged this policy of nonacquiescence. In *Lopez* v. *Heckler*, a class action suit in the ninth circuit, the judge refused to grant a stay, as requested by SSA, of the court's earlier medical improvement decisions. Currently, in the entire ninth circuit SSA is required by law to follow a medical improvement standard. However, in an unusual manner, Supreme Court Justice Rehnquist did grant SSA a partial stay by allowing SSA to avoid making interim payments to those who had been terminated from the rolls in the past who must be reevaluated under a medical improvement standard. The plaintiffs in the case then asked the Supreme Court to overturn the Rehnquist stay, but on October 11, 1983, the Court declined to hear the request, thereby allowing the Rehnquist stay to remain in force.

Presently, SSA is not processing CDI's in the third and fourth circuits due to unfavorable medical improvement cases pending resolution upon appeal. Tens of thousands of cases await Federal judicial consideration, and it is clear that courts will continue to rule SSA must implement a medical improvement standard until the Supreme Court considers this issue (1985 at the earliest).

### (C) MENTAL IMPAIRMENT DECISIONS

In two important class action suits, *Mental Health Association of Minnesota* v. *Schweiker* and *City of New York* v. *Heckler*, SSA has been found guilty of implementing a "covert and illegal policy that systematically discriminated against the mentally ill." Both courts ruled SSA must reopen the cases of all mentally impaired individuals initially denied benefits or terminated from the disability rolls, and reexamine their eligibility under lawful guidelines.

The essence of the illegal and "covert policy" consisted of SSA internal memoranda, returns, and reviews to State disability determination offices requiring that if an individual does not meet or equal the listing of impairments, that person can be *presumed* to be capable of performing unskilled work. That policy resulted in a virtual automatic denial of benefits to mentally impaired claimants under age 50.

In New York, District Judge Jack B. Weinstein argued that the result of "SSA's surreptitious undermining of the law" was "particularly tragic in the instant case because of its devastating effects on thousands of mentally ill persons whose very disability prevented them from effectively confronting the system." He also noted that by denying disability benefits to the mentally impaired, SSA simply transferred the costs of their care to the "social service agencies, hospitals, and shelters" of New York City and New York State.

Both courts found that SSA was not conducting the fourth step of the sequential evaluation—the evaluation of residual functional capacity—in accordance with the law. The assessment of RFC, if it was done at all was reduced to a "paper charade" in which any individual who did not meet or equal the listings was assumed, ipso facto, to be capable of unskilled work. Judge Weinstein summarized the implications of this policy in the following passage:

> The Social Security Act and its regulations require the Secretary to make a realistic, individual assessment of each claimant's ability to engage in substantial gainful ac-

tivity. The class plaintiffs did not receive that assessment. On the contrary, SSA relied on bureaucratic instructions rather than individual assessments and overruled the medical opinions of its own consulting physicians that many of those whose claims they were instructed to deny could not, in fact, work. Physicians were pressured to reach "conclusions" contrary to their own professional beliefs in cases where they felt, at the very least, that additional evidence needed to be gathered in the form of a realistic work assessment. The resulting supremacy of bureaucracy over professional medical judgments and the flaunting of published, objective standards is contrary to the spirit and letter of the Social Security Act.

## F. PROGNOSIS FOR 1984

In 1984, the social security disability program will unquestionably continue to serve as a major source of congressional interest, action, and controversy. As States continue to declare moratoria on the reviews, and as courts continue to rule against SSA, the lack of national uniformity in the program will have to be addressed, either legislatively or administratively.

# Part II

## LOW-INCOME ASSISTANCE PROGRAMS

Despite the historical emphasis on providing a reliable source of retirement income through social security, private pensions, and savings, public policy has long recognized the need for programs to supplement the basic incomes of those who do not qualify for earnings-related benefits or whose income from all sources is insufficient to maintain a minimum standard of living. Assistance programs have, therefore, played a vital role in assuring a minimum level of income to the poor and low-income elderly.

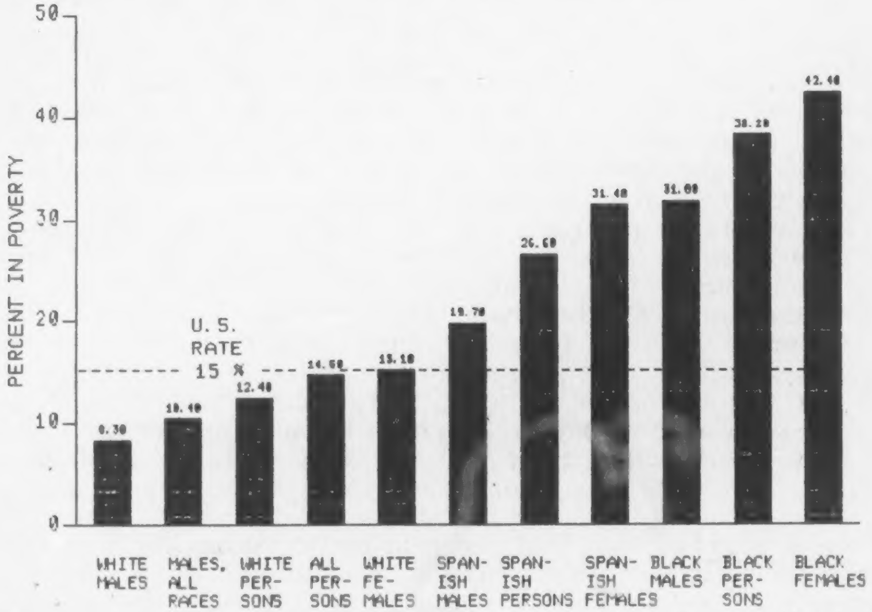
Four assistance programs play an especially important role in providing income support to the needy aged—supplemental security income (SSI), food stamps, assisted housing, and low-income energy assistance. On the whole, these programs fared well in 1983 as Congress declined to make any substantial programmatic changes in either food stamps, low-income energy assistance, or SSI. As part of the Social Security Amendments of 1983 (Public Law 98-21), Congress enacted a significant one-time increase in SSI benefits for individuals and couples, to compensate for the delay of COLA's. While overall appropriations for the food stamp program for fiscal year 1984 dropped by 8.6 percent from fiscal year 1983 levels, it is anticipated that program participation will drop with the declining rate of unemployment, and funding levels should be adequate to meet the need. Congress acted to increase the appropriation for the low-income energy assistance program (LIEAP) for fiscal year 1983 by $100 million above the authorized level of $1.875 billion, bringing the total appropriation for the year to $1.975 billion.

Fiscal year 1984 funding for 10,000 units of section 202 housing for the elderly and handicapped was provided by the Congress. However, no funds were appropriated for the section 8 new construction/rehabilitation and public housing new construction programs. This portion of section 8 was deauthorized in the Housing Act of 1983. (Both the housing and energy assistance programs are discussed in part IV.)

Recently, the character of the poverty debate has changed somewhat, particularly as regards the elderly. As mentioned in part 1, in 1982, the incidence of poverty among the elderly dropped to 14.6 percent, below that for the general population, though not below the rate for nonelderly adults. This new situation belies easy analysis and masks differing poverty levels among different segments of the elderly population. Elderly living alone, for example, have a poverty rate of 27.1 percent, black elderly, 38.2 percent. In addition, a significantly *higher* proportion of elderly than nonelderly are categorized as near-poor, that is their income is just above the poverty level. Despite this fact, the statistics have given rise to inferences on the part of some that relatively speaking, the elderly, as a group are among the better provided-for segments of society as regards government income and in-kind transfer.

CHART 1

SELECTED POVERTY RATES FOR THE AGED
BY SEX AND RACE
1982



Source: U.S. Bur. of the Census, Current Population Survey, March 1983

In fact, more than 3 million aged households in poverty receive no cash or noncash public assistance. And of those 30 percent of poverty households which do receive cash assistance, about two-thirds receive up to two noncash means-tested benefits in addition to the cash assistance. The distribution of means-tested assistance among these aged households whose income falls below the poverty level is clearly skewed. This uneven participation on the part of the population most in need continues to challenge public policymakers as they try to address the unmet needs of low-income elderly individuals and their families.

As evidenced by administration testimony before the House Ways and Means Subcommittee on Oversight, and on Public Assistance and Unemployment in the fall, the valuation of in-kind benefits in determining income has become an important focal point of the poverty policy discussion. OMB Director David Stockman argued that if in-kind benefits such as food stamps, medicare, and housing were given an imputed cash value according to their market value, the rate of poverty among the elderly would fall from 14.6 percent to as low as 3.7 percent. However, most analysts contend that the use of the market value standard is an extreme valuation of in-kind benefits. When alternative valuations of in-kind benefits are used, elderly poverty rates tend to be reduced only to between 7 and 11 percent.[1]

Most analysts caution that studies which attempt to reassess the poverty rate by assigning cash values to in-kind benefits are, to date, inexact and misleading. First, these studies have focused on government transfers alone, failing to take into account private in-kind transfers (such as employer-provided fringe benefits) which are made to the rest of society. Second, in reassessing the income of the poor by any valuation of noncash assistance, most studies utilize poverty measures based on cash income only. Third, there is considerable dispute as to which valuation of in-kind benefits best represents the value of these benefits: Market value, recipient value (cash equivalent), or poverty budget share.

Many critics of current revaluations of poverty postulate that if all these concerns were taken into account, the distribution of poor persons would not change significantly. Poverty is inherently a relative measure. Indeed it is possible that those "near-poor," who do not qualify for means-tested income assistance might drop to the lowest relative income levels.

Aside from the issue of adequacy of benefits, resources for Federal programs are increasingly recognized as being insufficient to meet the needs of all groups. Public policy in recent years has focused on the issue of targeting, the goal of spending limited Federal funds in a way that the benefits go exclusively to those who need them. This goal is particularly important in the case of means-tested programs which are aimed at assisting those with poverty or near-poverty incomes.

Unfortunately, relatively limited data exist which illustrate how well means-tested programs are targeted; and the data which do exist have serious deficiencies. In the early 1970's, the Department of Health and Human Services, along with the Bureau of the Census began development of a survey of income and program participation (SIPP) to fill this void. The income survey development program (ISDP) began collecting monthly income and program participation data of a representative sample in 1979. The findings of this survey include data on the receipt of different and multiple benefits.[2] In October 1983, the Census Bureau began fielding the operational phase of SIPP. The figures which follow reflect findings of the 1979 SIPP.

Table 1 presents the number of households that received each of five selected types of benefits in 1979, as well as the percentage of each that also received benefits from one or more of the other selected programs. The social security benefits and the unemployment benefits shown in the table are not means-tested benefits, they are payable as a matter of right to individuals who meet the eligibility requirements. Also, the benefits included in table 1 do not include all the noncash means-tested benefits available, such as medicaid or public housing subsidies. Despite these limitations, the table provides a useful measure of the degree to which means-tested benefits supplement other benefits, both those which are means-tested and those which are not. It shows that more than four-fifths of the households receiving food stamps or public assistance, and more than three-fourths of those receiving SSI payments, also received at least one of the other types of benefits under consideration. Far smaller proportions of the households receiving earnings-related entitlements were also in receipt of at least one of the other selected benefits. Only 16 percent of those with social security (OASDI) and 28 percent of those receiving unemployment compensation also received one of the other benefits.

---

[1] U.S. Dept. of Commerce. Bureau of the Census. Alternative Methods for Valuing Selected In-kind Transfer Benefits and Measuring Their Effect on Poverty. Washington, U.S. Govt. Print. Off., 1982.

[2] Ycas, Martynas A., and Charles A. Lininger. The Income Survey Development Program: Design Features and Initial Findings. Social Security Bulletin. November 1981, v. 44, No. 11, pp. 13-19.

TABLE 1.—HOUSEHOLDS RECEIVING BENEFITS FROM ONE OR MORE OF FIVE MAJOR PROGRAMS IN EARLY 1979 [1]

| Source of benefits | Total number of beneficiary households (in thousands) | Percentage distribution | | | Approximate standard error of percentage |
|---|---|---|---|---|---|
| | | Total | Benefits under one program | Benefits under more than one program [1] | |
| Social security program | 21,917 | 100 | 83.8 | 16.2 | 0.8 |
| Food stamps | 5,234 | 100 | 16.6 | 83.4 | 1.9 |
| Unemployment compensation | 4,154 | 100 | 72.3 | 27.7 | 2.3 |
| Federally administered SSI | 3,615 | 100 | 23.3 | 76.7 | 2.6 |
| Public assistance [2] | 3,295 | 100 | 16.8 | 83.2 | 2.4 |

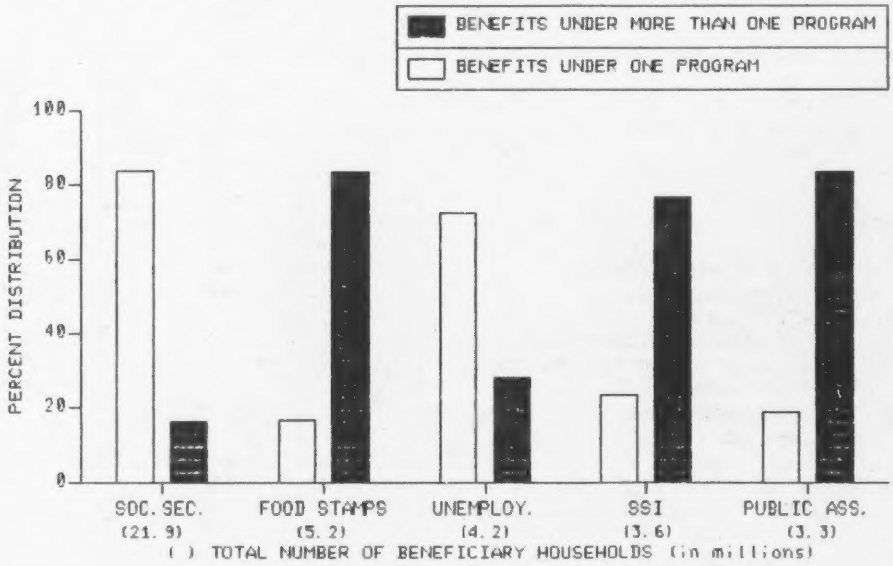
[1] Each wave of the 1979 panel has a fixed reference period of 3 months. The overall panel, however, was divided into three equally sized, independent subsamples interviewed at monthly intervals beginning in February 1979. Thus, the calendar reference months for each subsample are overlapping but not the same. For the February 1973 subsample, the reference months are November and December 1978 and January 1979; for the March subsample, December 1978 and January and February 1979; and for the April subsample, January, February, and March 1979.

[2] Public assistance includes AFDC payments, general assistance, emergency assistance, and other cash welfare payments received from State or local welfare departments, excluding State-administered supplemental security income payments. In early 1979, about 60,000 individuals were receiving State-administered but not federally administered payments. About 200,000 other recipients of State-administered SSI payments were concurrently receiving federally administered payments and are included in that row of the table.

Source: Social Security Bulletin, November 1981.

CHART 2

HOUSEHOLDS RECEIVING BENEFITS
FROM ONE OR MORE OF FIVE PROGRAMS IN EARLY 1979



SOURCE: SOCIAL SECURITY BULLETIN, NOVEMBER 1981, Vol. 44 No. 11

But as table 2 shows, it is only a minority of households which receive benefits from one or more of the five selected programs. Of the 30 million households receiving benefits, nearly 80 percent received only one benefit, and this was generally social security benefits. Only 21 percent received benefits from two or more programs, the vast majority of those recipients receiving only two of the benefits.

## TABLE 2.—PATTERNS OF MULTIPLE RECEIPT OF BENEFITS UNDER FIVE MAJOR PROGRAMS [1] IN EARLY 1979 [2]

[Household units]

| Source and pattern of benefits [3] | Number of households (in thousands) | Approximate standard error | Percentage distribution |
|---|---|---|---|
| Households receiving one or more of the five types of assistance | 30,025 | 509 | 100.0 |
| Only one type of assistance | 23,642 | 464 | 78.7 |
| OASDI only | 18,375 | 414 | 61.2 |
| Unemployment compensation only | 3,005 | 176 | 10.0 |
| Food stamps only | 868 | 111 | 2.9 |
| SSI | 842 | 109 | 2.8 |
| Public assistance only | 552 | 88 | 1.8 |
| Two or more types of assistance | 6,383 | 332 | 21.3 |
| Only two | 4,726 | 278 | 15.7 |
| Food stamps and public assistance | 1,585 | 152 | 5.3 |
| OASDI and SSI | 1,128 | 127 | 3.8 |
| OASDI and food stamps | 527 | 86 | 1.8 |
| OASDI and unemployment compensation | 459 | 80 | 1.5 |
| Unemployment compensation and food stamps | 379 | 96 | 1.3 |
| SSI and food stamps | 361 | 71 | 1.2 |
| OASDI and public assistance | 199 | 52 | .7 |
| Other combinations | 88 | 30 | .3 |
| Three or more types of assistance | 1,657 | 156 | 5.6 |
| Only three | 1,507 | 148 | 5.1 |
| OASDI, SSI, and food stamps | 773 | 105 | 2.6 |
| OASDI, food stamps, and public assistance | 210 | 54 | .7 |
| SSI, food stamps, and public assistance | 189 | 51 | .6 |
| Unemployment compensation, food stamps, and public assistance or OASDI | 193 | 45 | .6 |
| OASDI, SSI, and public assistance | 142 | 44 | .5 |
| Four or more types of assistance | 150 | 46 | .5 |
| OASDI, SSI, food stamps, and public assistance | 90 | 35 | .3 |
| Other combinations | 60 | 25 | .2 |

---

[1] Cash payments for old-age, survivors, and disability insurance (OASDI), federally administered supplemental security income (SSI), public assistance, unemployment compensation, and food stamps. Other benefit programs were excluded; had any of them been included, multiple program participation would have increased.

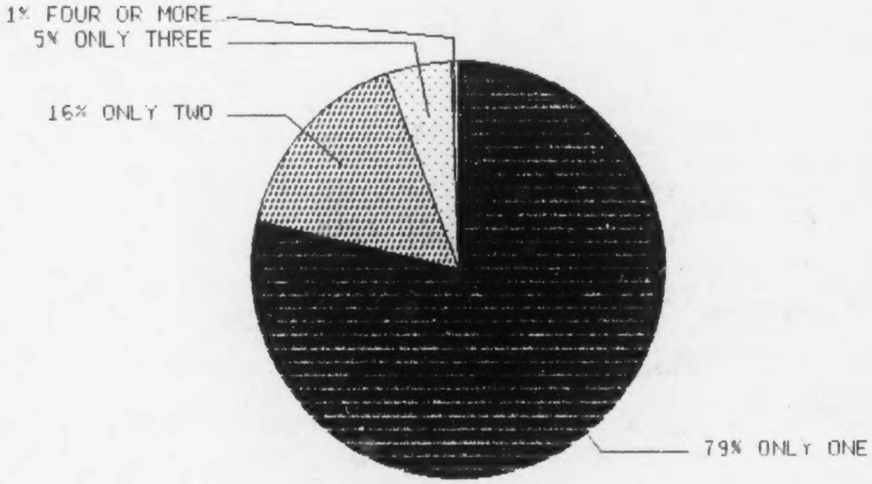
[2] See footnote 1, table 1.

[3] See footnote 2, table 1.

Source: Social Security Bulletin, November 1981.

## CHART 3

PATTERNS OF MULTIPLE RECEIPTS OF BENEFITS
UNDER FIVE PROGRAMS IN 1979



MULTIPLE RECEIPT OF BENEFITS

SOURCE: SOCIAL SECURITY BULLETIN 1981/Vol. 44, No. 11

The most recent data on the multiple receipt of means-tested cash and noncash benefits by the elderly is shown in table 3, compiled by the Census Bureau. Table 3 shows the number of households in which the head of the household is age 65 and over, and the number of such households receiving means-tested benefits. Among the 17.7 million households with an aged person as head of the household, in March 1983, 3 million, or some 18.4 percent, fell below the Federal Government's 1982 poverty line. Yet nearly 70 percent of these households in poverty did not receive any cash public assistance, such as supplemental security income (SSI). Just about 50 percent of this poverty group did not receive any noncash means-tested assistance, such as medicaid, food stamps, or public housing subsidies. Forty-nine percent (1.5 million) of the households in poverty received neither cash public assistance nor noncash public assistance.

TABLE 3.—HOUSEHOLDS WITH A HEAD OF HOUSEHOLD AGE 65 AND OVER:[1] BY NUMBER OF SELECTED CASH AND NONCASH MEANS-TESTED PUBLIC ASSISTANCE BENEFITS RECEIVED, AND POVERTY STATUS, 1982

[Numbers in thousands]

| Noncash benefits | All income levels | | | Below current poverty level [2] | | | Above poverty level [2] | | |
|---|---|---|---|---|---|---|---|---|---|
| | Total | Not receiving cash public assistance [3] | Receiving cash public assistance [3] | Total | Not receiving cash public assistance [3] | Receiving cash public assistance [3] | Total | Not receiving cash public assistance [3] | Receiving cash public assistance [3] |
| Total | 17,671 | 16,106 | 1,565 | 3,022 | 2,099 | 922 | 16,649 | 14,006 | 642 |
| Not receiving noncash benefit | 14,251 | 14,167 | 83 | 1,499 | 1,459 | 40 | 12,752 | 12,709 | 43 |
| Receiving at least 1 noncash benefit | 3,420 | 1,939 | 1,481 | 1,523 | 641 | 822 | 1,897 | 1,298 | 599 |
| Receiving 1 noncash benefit only [4] | 2,413 | 1,716 | 697 | 794 | 500 | 294 | 1,619 | 1,216 | 403 |
| Receiving 2 noncash benefits [4] | 822 | 192 | 631 | 580 | 117 | 462 | 243 | 74 | 168 |
| Receiving 3 noncash benefits [4] | 181 | 29 | 152 | 147 | 22 | 125 | 34 | 7 | 27 |
| Receiving all 4 noncash benefits [4] | 3 | 2 | 2 | 2 | 2 | 0 | 1 | 0 | 1 |

[1] Households as of March 1983.

[2] Households are classified according to the poverty status of the family or the nonfamily head of household, based on income for 1982 and the poverty level for 1982.

[3] Means-tested cash public assistance: SSI, AFDC, or other cash assistance, such as general assistance, emergency assistance, refugee assistance.

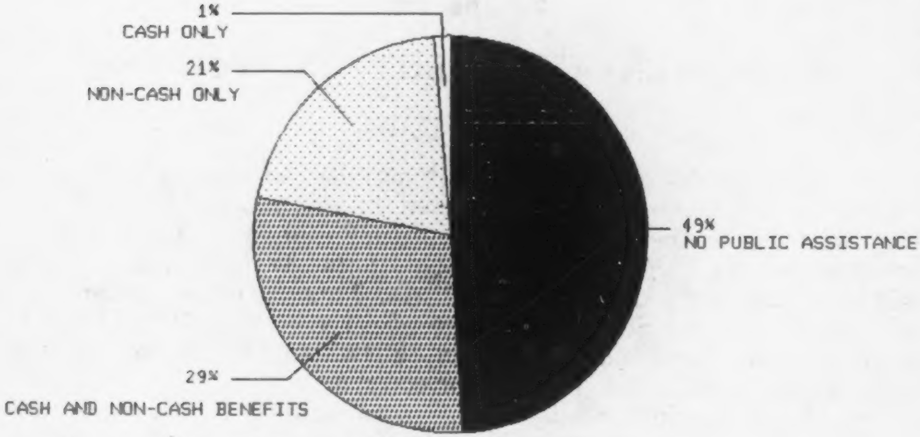
[4] Means-tested noncash public assistance benefits: Food stamps, free or reduced-price school lunches, publicly owned or other subsidized housing.

Source: U.S. Dept. of Commerce. Census Bureau.

Among the 30.5 percent of aged households below the poverty line which received cash assistance, about 96 percent received at least one noncash means-tested benefit in addition. Of this group receiving both cash and noncash public assistance (882,000 households), about 33 percent received only one noncash benefit in addition to the cash benefit. More than half received two noncash benefits in addition to the cash assistance.

CHART 4

DISTRIBUTION OF CASH AND NON-CASH PUBLIC ASSISTANCE
AMONG HOUSEHOLDERS AGE 65 AND OVER
AND WITH INCOMES BELOW THE POVERTY LEVEL



SOURCE: BUREAU OF THE CENSUS, UNPUBLISHED DATA

In conclusion, it is apparent from these data that the numbers of persons currently eligible for programs in which they do not participate is alarmingly high. While many of those eligible choose not to participate, some are ignorant of their eligibility. The goal of reaching these elderly poor continues to challenge Federal policymakers.

# Chapter 8

# SUPPLEMENTAL SECURITY INCOME (SSI)

## OVERVIEW

In 1983, the major congressional activity addressing SSI were provisions in the social security amendments, most notably a one-time increase in the payment standard ($20 for individuals, $30 for couples) to offset the negative effects of the 6-month delay in the SSI cost-of-living adjustment (COLA). This increase raised the maximum monthly SSI benefits significantly. In July 1983, the payment standard was increased from $284.30 to $304.30 for individuals and from $426.40 to $456.40 for couples.

The 1983 amendments also contained a number of other changes in SSI, including a provision disregarding certain in-kind assistance provided SSI recipients by private, nonprofit organizations; a stipulation that an SSI alert be initiated in 1984; and a liberalization of eligibility requirements for temporary, homeless residents of emergency shelters.

The other major area of congressional interest in SSI stemmed from the continuing eligibility reviews of disability recipients. Legislation to comprehensively reform the disability review process was not enacted in 1983, and it will most likely be a subject of congressional attention in 1984. The temporary special benefits for severely disabled SSI recipients who engage in employment, mandated by the Social Security Disability Amendments of 1980, expired at the end of 1983. Their extension is pending congressional approval. In recent years, SSI has been considered a major element in the "social safety net," and has largely escaped significant budget reductions, unlike many other means-tested public assistance programs. In 1983, this trend continued, and in fact, benefits were actually increased.

## A. BACKGROUND

The supplemental security income (SSI) program provides a guaranteed minimum income to the Nation's aged, blind, and disabled. Enacted in 1972 as title XVI of the Social Security Act, SSI was designed to establish a uniform, national income floor to insure the economic security of America's most needy and vulnerable groups. Currently, just under 3.9 million people receive benefits from SSI, with maximum Federal monthly benefits amounting to $314 for individuals and $472 for couples. SSI is financed through general revenues, and is administered by the Social Security Administration. (SSA).

SSI was created to consolidate at the Federal level three State-administered public assistance programs: old-age assistance (OAA), aid to the blind (AB), and aid to the permanently and totally disabled (APTD). The advantages of Federal financing and administration were numerous. States were fiscally relieved from fast-expanding income assistance programs, wide interstate variation in eligibility standards and benefit levels was eliminated, and it was assumed that SSI's affiliation with SSA, and thereby the concept of "social insurance," would reduce the stigma of "welfare."

The initial implementation of SSI posed immense administrative problems for SSA. Individual State and local recordkeeping systems, 1,350 in all, containing the files of over 3 million beneficiaries, had to be converted into a single, unified information system, capable of calculating benefit levels from very complicated eligibility criteria, and disbursing monthly payments accurately. Allowed 1 year and 2 months between the enactment of the Social Security Amendments of 1972, which authorized SSI, and January 1, 1974, the date the program was to be implemented, SSA was severely strained to construct an administrative apparatus equal to the task it had been assigned. In the first year-and-a-half of actual program operation, almost 25 percent of all SSI checks involved payment errors, and as much as 10 percent of all benefits dispensed were overpayments.[1]

Despite initial technical difficulties, the basic structure of SSI has changed little during the first 10 years of its operation. Legislation addressing SSI has been oriented primarily toward improving administrative efficiency, increasing intraprogram equity, and protecting former recipients of the State programs from losing benefits due to federalization.

## B. PROGRAM DESCRIPTION

### 1. Eligibility

To qualify for SSI, an individual must be either 65 or over, blind, or disabled, and demonstrate need for income supplementation. Need is determined through a "means test," which is an evaluation of income and assets in relation to established maximum standards. Currently, recipients cannot receive in income more than the maximum Federal SSI benefit ($314 for individuals, $472 for couples), excluding certain disregarded income. To be eligible for SSI, assets may not exceed $1,500 for an individual or $2,200 for couples. However, in assessing assets, the value of a person's home is not counted, nor are the first $4,500 in fair market value for an automobile and the first $2,000 in equity value for household goods and personal effects. Regulations also provide guidelines for determining the countable value of certain other assets, such as burial plots and life insurance policies. Eligibility criteria for SSI are summarized below:

---

[1] Chang, Gordon A. The Supplemental Security Income Program: The "Revolution" Needs Reform. Cornell Law Review, v. 62, January 1977. p. 317.

TABLE 1.—*Basic SSI eligibility conditions*

| | |
|---|---|
| Aged | 65 or older. |
| Blind | Vision no better than 20/200 or limited visual field of 20 degrees or less with the best corrective eyeglasses. |
| Disabled | A physical or mental impairment which prevents a person from doing any substantial work and is expected to last at least 12 months or result in death. |
| Resource limits [1] | $1,500 per individual; $2,250 per couple. |
| Income limits [2] | Below $314 a month per individual; below $472 a month per couple. |
| Citizenship | U.S. citizen or immigrant lawfully admitted for permanent residence or otherwise residing in the United States under color of law. |
| Residency | Resident of the United States or the Northern Mariana Islands. |

[1] Not all resources are counted in determining eligibility.

[2] Not all income is counted in determining eligibility. Also, a person may have income above the limit and possibly be eligible for a State supplement only, but the income levels vary with each State.

NOTE.—Disabled must accept vocational rehabilitation if available. Disabled addicts and alcoholics must accept appropriate treatment if available.

Once an individual has been determined to be eligible for SSI, it is up to that person to continually notify SSA of any changes in income and assets that may develop over time. One of the most heavily criticized aspects of SSI is the penalty that exists for exceeding the assets level—currently, if a recipient goes over the limit by even a small amount, perhaps from interest in a bank account, that person is deemed ineligible for SSI in the month or months in which there is an excess. This ineligibility usually leads to substantial overpayments, due to the fact the error is detected after the full benefits have been paid to the recipient. In essence, if an SSI beneficiary exceeds the assets limit by $10, that individual's total benefit is eliminated; rather than reduced $10. This penalty has been criticized as excessive in relation to the error.

This problem has been exacerbated by SSA's recent policy of aggressively recovering overpayments, and rarely waiving the obligation to pay back to SSA the funds overpayed. Presently, approximately 20 percent of all overpayment errors in SSI result from problems associated with bank accounts. Significantly, these errors account for about 50 percent of the dollar amount to be collected as overpayments.[2]

### 2. BENEFITS

Since January 1984, the maximum Federal monthly payment is $314 for an eligible individual and $472 for an eligible couple. The law requires a benefit reduction of one-third for those who live in another person's household and who receive support and maintenance from that person or persons. Many groups, including the 1981 National Commission on Social Security, have recommended elimination of the one-third reduction. It is a very complex provision to administer, and it serves as a disincentive to SSI beneficiaries to live with other people, which is often seen as a desirable social goal, given the mental and physical disadvantages of many SSI recipients.

---

[2] Social Security Administration, Office of Assessment, Office of Assistance Program Quality. SSI Quality Assurance Findings: April to September 1982.

Persons residing in public institutions are usually ineligible for SSI benefits. However, if a person lives in a community care facility serving no more than 16 people, that individual can often receive SSI benefits. Residents of larger health care institutions, where medicaid pays for more than half of that individual's care, are eligible for a maximum $25 monthly SSI benefit, which is intended to cover personal comfort items.

States are encouraged to supplement the Federal SSI benefits voluntarily to provide a higher level of assistance than the Federal program provides. More than half of the States are currently supplementing the Federal benefits for aged individuals who live independently.

Other States provide supplements to persons in specific circumstances. States may elect to administer their own optional supplementary payments, or may contract with the Social Security Administration for Federal administration so that the combined monthly payment of Federal and State benefits is included in a single check issued by the Federal Treasury.

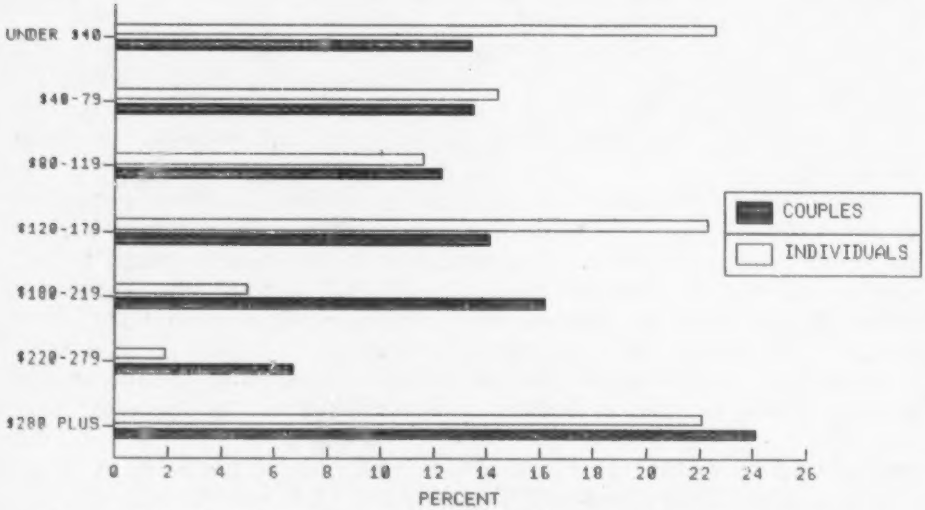
Under a "grandfather" clause, States must also maintain the benefit levels of former public assistance recipients transferred to the SSI program. These mandatory supplements may also be administered by either the Federal Government or the State, at State election. If a State chooses Federal administration of its State supplements, the cost of administration is paid by the Federal Government. Under this option, the State must generally make supplements to all those who meet Federal eligibility rules. If a State elects to administer its own supplementation program, it must pay the cost, but may restrict eligibility to a more limited population.

Since July 1977, States which supplement Federal SSI benefits have been required to pass through Federal SSI cost-of-living increases. A State can meet this requirement by either (1) maintaining the December 1976 level of State supplementation payment for recipients; or (2) providing no less than the total aggregate amount of State supplementation paid by the State in the previous 12-month period. This passthrough provision was modified by the Social Security Amendments of 1983. The new law requires States to maintain the levels of supplementation existent in March 1983, rather than December 1976. It also provides that States only have to pass through the amount of the SSI benefit increase that would have occurred if the July 1983 COLA had not been delayed 6 months, rather than the full increase in the benefit levels.

Federally administered SSI benefits are financed through U.S. general revenues. In 1983, total outlays for SSI amounted to approximately $7.8 billion. The average total monthly benefit for aged recipients was just under $160 in July 1983. Over one-fifth of the SSI population received benefits of $280 or more. The distribution of SSI beneficiaries, by monthly payment amount, is graphically defined below:

CHART 1

DISTRIBUTION OF SSI RECIPIENTS BY MONTHLY PAYMENT AMOUNT
DECEMBER 1982

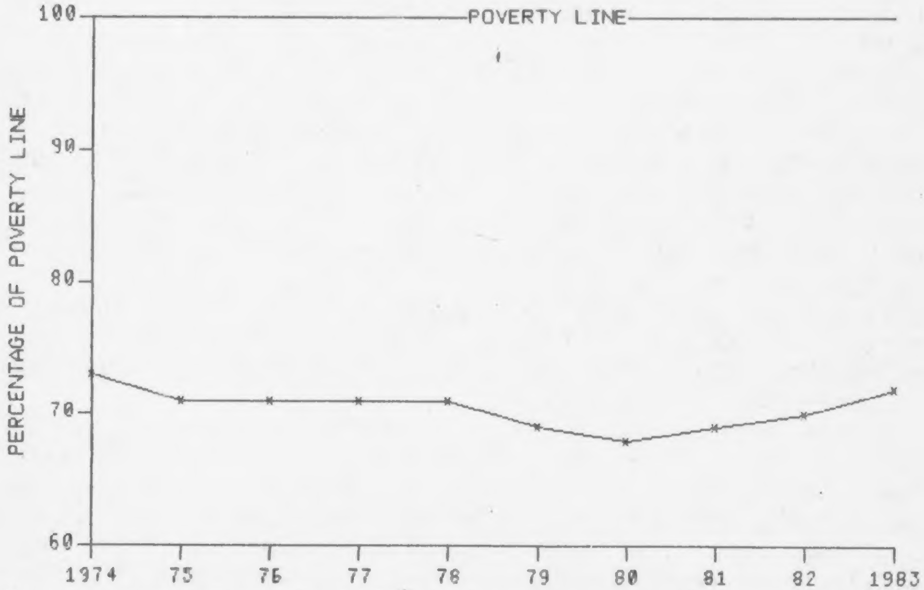


Source: SSA, Office of Research and Statistics, August, 1983

In the second half of 1983, the maximum monthly benefit for individuals ($304.30) equaled 78 percent of the national poverty line. Couples' maximum benefits ($452.40) attained 84 percent of the poverty level. The degree to which SSI maximum monthly benefits have approximated the poverty line is delineated graphically below.

## CHART 2

COMPARISON OF YEARLY SSI BENEFITS TO
THE POVERTY LINE, FOR INDIVIDUALS
1974-1983



Source: Social Security Administration, January, 1984

Currently, about 3.9 million persons receive federally administered SSI payments. Of those receiving benefits, about 1.5 million recipients qualify by reason of age; and 2.4 million by reason of disability or blindness. Nineteen percent of disabled recipients and 31 percent of blind recipients are over the age of 65, however, and are not classified as "aged recipients" because they initially qualified under the program by reason of disability or blindness.

TABLE 2.—SSI: NUMBER OF PERSONS RECEIVING FEDERALLY ADMINISTERED PAYMENTS AND TOTAL AMOUNT, BY REASON FOR ELIGIBILITY, SEPTEMBER 1983

| Reason for eligibility | Number | Amount of payments (in thousands) | | |
|---|---|---|---|---|
| | | Total | Federal SSI | State supplementation [1] |
| Total | 3,898,256 | $828,061 | $679,428 | $148,633 |
| Aged | 1,527,500 | 242,063 | 187,441 | 54,622 |
| Blind | [2] 78,820 | 20,191 | 15,347 | 4,843 |
| Disabled | [3] 2,291,936 | 565,807 | 476,639 | 89,168 |

[1] Excludes payments for State supplementation under State-administered programs.
[2] Includes approximately 23,200 persons aged 65 and over.
[3] Includes approximately 453,000 persons aged 65 and over.

## 3. PARTICIPATION

Despite initial projections that over 7 million Americans would participate in SSI, the total SSI caseload has never exceeded 4.5 million. Early assumptions that over 90 percent of the eligible population would benefit from SSI were proven too optimistic; in reality, a conservative estimate of the participation rate is closer to 60 percent.

Jennifer Warlick, in an analysis of the 1975 Current Population Survey, estimated SSI participation at 50 percent for the eligible aged.[3] In a separate study employing a set of special questions regarding SSI as part of the 1980 Survey of the Panel Study on Income Dynamics (an annual, longitudinal survey of 5,000 families), Richard Coe found the elderly participation rate to be 52 percent.[4] SSA estimates that 65 to 70 percent of the eligible population participates in SSI.[5]

Explaining these low levels of participation is difficult. Few surveys of the attitudes and opinions of the SSI population have been undertaken, and alternative interpretations of the problem have often been based upon anecdotal information.

Typical reasons explaining the low participation of the elderly in SSI include: (a) The stigma associated with welfare; (b) very small benefit amounts for many who are near the maximum income and resource limits; (c) barriers of literacy, mental and physical handicap, and access to transportation; and (d) SSI's administrative complexity, which requires a great deal of effort on the part of participants.

An attitudinal survey of SSI participants and nonparticipants, conducted by Urban Systems Research and Engineering in 1981, found that "the big problem seems to be a lack of awareness—of the availability of SSI, of the purpose of SSI, of their eligibility for SSI." Few nonparticipants had ever heard of SSI, and many of those that had could not distinguish SSI from social security.[6]

Low participation and, in fact, declining participation, has been significant among the aged. In 1950, over 2.8 million aged received benefits from OAA. Currently, only one-half that number participate in SSI. Between 1974 and 1980, the population of the country over age 65 increased from 21.8 to 25.5 million; yet the proportion of those over age 65 who receive SSI payments declined from 10.5 percent in 1974 to 8.7 percent in 1980. Only the District of Columbia and California showed an increase in persons over age 65 enrolled in the SSI program.

---

[3] Warlick, Jennifer L., Participation of the Aged in SSI. Journal of Human Resources, v. 17, Spring 1982. pp. 236-260.

[4] Coe, Richard D., Participation in the Supplemental Security Income Program by the Eligible Elderly. In 5000 American Families—Patterns of Economic Progress. Ann Arbor, University of Michigan, 1983. pp. 93-118.

[5] Menefee, John A., Bea Edwards, and Sylvester J. Schieber. Analysis of Nonparticipation in the SSI Program. Social Security Bulletin, v. 44, June 1981. pp. 3-21.

[6] Worthington, Mark et. al. SSI Aged: A Pilot Study of Eligibility and Participation in the Supplemental Security Income Program. Cambridge, Mass. Urban Systems Research and Engineering, 1981.

TABLE 3.—NUMBER AND PERCENT OF U.S. POPULATION AGED 65 OR OLDER RECEIVING FEDERALLY ADMINISTERED SSI PAYMENTS, BY REGION, DIVISION, AND STATE, DECEMBER 1974 AND DECEMBER 1980

| Region, division, and State | Population aged 65 or older (in thousands) | | SSI recipients aged 65 or older | | Percent of population receiving SSI | |
|---|---|---|---|---|---|---|
| | 1974[1] | 1980[2] | 1974 | 1980 | 1974 | 1980 |
| United States | 21,815 | 25,542 | 2,285,909 | 2,225,797 | 10.5 | 8.7 |
| Northeast | 5,440 | 6,072 | 389,768 | 395,890 | 7.2 | 6.5 |
| New England | 1,345 | 1,520 | 114,652 | 109,790 | 8.5 | 7.2 |
| Maine | 122 | 141 | 12,998 | 11,474 | 10.7 | 8.1 |
| New Hampshire | 86 | 103 | 3,173 | 2,521 | 3.7 | 2.4 |
| Vermont | 51 | 58 | 4,702 | 4,499 | 9.2 | 7.7 |
| Massachusetts | 661 | 727 | 77,944 | 73,781 | 11.8 | 10.2 |
| Rhode Island | 111 | 127 | 6,870 | 7,907 | 6.2 | 6.2 |
| Connecticut | 314 | 364 | 8,965 | 9,608 | 2.9 | 2.6 |
| Middle Atlantic | 4,095 | 4,552 | 275,116 | 286,100 | 6.7 | 6.3 |
| New York | 1,998 | 2,161 | 171,712 | 172,965 | 8.6 | 8.0 |
| New Jersey | 749 | 860 | 38,087 | 40,516 | 5.1 | 4.7 |
| Pennsylvania | 1,348 | 1,531 | 65,317 | 72,619 | 4.8 | 4.7 |
| North Central | 6,020 | 6,689 | 351,832 | 304,449 | 5.8 | 4.6 |
| East North Central | 4,009 | 4,491 | 209,833 | 202,051 | 5.2 | 4.5 |
| Ohio | 1,050 | 1,169 | 54,311 | 45,941 | 5.2 | 3.9 |
| Indiana | 522 | 585 | 23,819 | 18,378 | 4.6 | 3.1 |
| Illinois | 1,134 | 1,261 | 46,386 | 52,060 | 4.1 | 4.1 |
| Michigan | 798 | 912 | 49,311 | 49,512 | 6.2 | 5.4 |
| Wisconsin | 505 | 564 | 36,006 | 36,160 | 7.1 | 6.4 |
| West North Central | 2,011 | 2,198 | 141,999 | 102,398 | 7.1 | 4.7 |
| Minnesota | 432 | 480 | 19,803 | 16,835 | 4.6 | 3.5 |
| Iowa | 360 | 387 | 17,710 | 12,739 | 4.9 | 3.3 |
| Missouri | 591 | 648 | 71,453 | 47,948 | 12.1 | 7.4 |
| North Dakota | 72 | 80 | 5,056 | 3,830 | 7.0 | 4.8 |
| South Dakota | 84 | 91 | 5,718 | 4,485 | 6.8 | 4.9 |
| Nebraska | 191 | 206 | 9,137 | 6,586 | 4.8 | 3.2 |
| Kansas | 281 | 306 | 13,122 | 9,975 | 4.7 | 3.3 |
| South | 6,893 | 8,483 | 1,122,273 | 1,029,243 | 16.3 | 12.1 |
| South Atlantic | 3,440 | 4,363 | 387,801 | 410,988 | 11.3 | 9.4 |
| Delaware | 48 | 59 | 3,490 | 3,141 | 7.3 | 5.3 |
| Maryland | 333 | 396 | 17,580 | 21,037 | 5.3 | 5.3 |
| District of Columbia | 71 | 74 | 5,392 | 6,383 | 7.6 | 8.6 |
| Virginia | 410 | 505 | 38,202 | 41,772 | 9.3 | 8.3 |
| West Virginia | 206 | 238 | 20,446 | 17,945 | 9.9 | 7.5 |
| North Carolina | 473 | 602 | 74,776 | 79,774 | 15.8 | 13.2 |
| South Carolina | 219 | 287 | 43,098 | 47,121 | 19.7 | 16.4 |
| Georgia | 413 | 517 | 94,868 | 88,063 | 23.0 | 17.0 |
| Florida | 1,267 | 1,685 | 89,949 | 105,752 | 7.1 | 6.3 |
| East South Central | 1,404 | 1,657 | 325,298 | 282,573 | 23.2 | 17.1 |
| Kentucky | 364 | 410 | 59,555 | 49,493 | 16.4 | 12.1 |
| Tennessee | 429 | 518 | 77,007 | 73,525 | 18.0 | 14.2 |
| Alabama | 365 | 440 | 103,683 | 87,464 | 28.4 | 19.9 |
| Mississippi | 246 | 289 | 85,053 | 72,091 | 34.6 | 24.9 |
| West South Central | 2,049 | 2,463 | 409,174 | 335,682 | 20.0 | 13.6 |
| Arkansas | 264 | 312 | 60,138 | 50,706 | 22.8 | 16.2 |
| Louisiana | 337 | 404 | 99,820 | 76,889 | 29.6 | 19.0 |
| Oklahoma | 328 | 376 | 54,797 | 41,385 | 16.7 | 11.0 |
| Texas | 1,120 | 1,371 | 194,419 | 166,702 | 17.4 | 12.2 |
| West | 3,463 | 4,298 | 421,928 | 496,200 | 12.2 | 11.5 |
| Mountain | 811 | 1,061 | 64,354 | 58,119 | 7.9 | 5.5 |
| Montana | 73 | 85 | 3,942 | 2,987 | 5.4 | 3.5 |
| Idaho | 76 | 94 | 4,289 | 3,349 | 5.6 | 3.6 |
| Wyoming | 32 | 37 | 1,394 | 925 | 4.4 | 2.5 |
| Colorado | 204 | 247 | 21,689 | 15,304 | 10.6 | 6.2 |
| New Mexico | 86 | 116 | 12,016 | 13,848 | 14.0 | 12.0 |
| Arizona | 211 | 307 | 13,842 | 14,678 | 6.6 | 4.8 |

TABLE 3.—NUMBER AND PERCENT OF U.S. POPULATION AGED 65 OR OLDER RECEIVING FEDERALLY ADMINISTERED SSI PAYMENTS, BY REGION, DIVISION, AND STATE, DECEMBER 1974 AND DECEMBER 1980—Continued

| Region, division, and State | Population aged 65 or older (in thousands) | | SSI recipients aged 65 or older | | Percent of population receiving SSI | |
|---|---|---|---|---|---|---|
| | 1974 [1] | 1980 [2] | 1974 | 1980 | 1974 | 1980 |
| Utah | 88 | 109 | 3,692 | 3,186 | 4.2 | 2.9 |
| Nevada | 41 | 66 | 3,490 | 3,842 | 8.5 | 5.8 |
| Pacific | 2,652 | 3,237 | 357,574 | 438,081 | 13.5 | 13.5 |
| Washington | 354 | 431 | 21,157 | 19,789 | 6.0 | 4.6 |
| Oregon | 251 | 303 | 11,063 | 9,538 | 4.4 | 3.1 |
| California | 1,986 | 2,415 | 318,835 | 401,496 | 16.1 | 16.6 |
| Alaska | 8 | 12 | 1,516 | 1,511 | 19.0 | 13.1 |
| Hawaii | 53 | 76 | 5,003 | 5,747 | 9.4 | 7.5 |

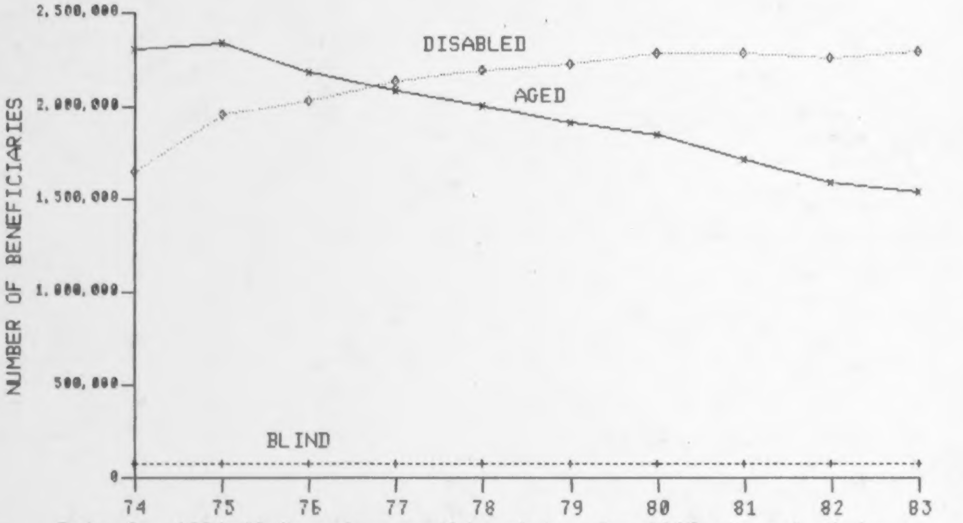
[1] Bureau of the Census, Statistical Abstract of the United States, 1975, table 36. Data as of July 1.
[2] Bureau of the Census, 1980 Census of Population, Supplementary Reports (PC-80-S1-1), table 2.

Source: Social Security Bulletin, July 1982, vol. 45, No. 7.

The actual number of SSI recipients, initially at 3.2 million blind, aged, and disabled persons, rose to 4.4 million in 2 years and then gradually declined to 4.2 million by the end of 1980. Trends in the SSI caseload are summarized graphically below.

CHART 3

RELATIVE PROPORTION OF AGED, BLIND, AND DISABLED SSI BENEFICIARIES
1974-1983



Data for 1974-82 December monthly stats.; for 1983, August stats.
Source: SSA Annual Stat. Supplement, 1982; Monthly Benefit Stat., October, 1983

### 4. SSI and Other Public Assistance Programs

SSI recipients often qualify for additional Federal public assistance from a variety of programs, most notably medicaid and food stamps. The relationship between SSI and these programs has changed over the last decade. Originally, SSI beneficiaries were prevented by statute from receiving food stamps. This exclusion was eliminated in 1977 by Congress, by virtue of the fact that it seemed inequitable that AFDC recipients, as well as people whose income or assets exceeded SSI limits, could qualify for food stamps while SSI beneficiaries could not. Currently, SSI recipients can apply for food stamps in SSA district offices, where eligibility determinations are made in accordance with conventional food stamp guidelines. In California and Wisconsin, food stamps are "cashed out," or converted into cash as part of monthly SSI payments.

States are required to offer medicaid to SSI recipients if the recipients are eligible under the State's 1972 eligibility criteria. The 1972 legislation creating SSI gave States the option of allowing SSA to determine medicaid eligibility, if the States were willing to accept SSI eligibility as a condition for medicaid coverage. Currently, more than half the States have SSA execute medicaid determinations for SSI recipients. Medicaid is perhaps the most valuable ancillary Federal program for SSI beneficiaries, and adds significantly to the adequacy of SSI coverage.

During the closing days of the 97th Congress, legislation was enacted to exclude from the calculation of countable income any need-based private home energy assistance payments for SSI recipients. The exclusion applies to cash or in-kind home energy assistance if it is supplied by a private or public home energy provider. Nonprofit charitable organizations may contribute funding to the suppliers to subsidize this assistance, but they are prohibited from giving cash directly to SSI recipients. Assistance of this type provided by a nonprofit organization would also be excluded from income but only if it is in-kind assistance, i.e., it is paid directly to the supplier and not to the recipient. The legislation, which took the form of an amendment to the Surface Transportation Act of 1982 (Public Law 97-424), applies to assistance provided from the month after enactment through June 1985. Prior to April 1985, the Secretary of Health and Human Services is required to report on the implementation of this change.

## C. RECENT DEVELOPMENTS IN SSI

### 1. The Social Security Amendments of 1983

The Social Security Amendments of 1983 (Public Law 98-21) included five provisions affecting SSI. The most significant of these is the 6-month delay of the SSI COLA from July 1983 to January 1984, accompanied by an offsetting increase in the SSI payment standard. The SSI COLA will now occur annually in January, in conjunction with the social security COLA. SSI COLA's will continue to be linked to increases in the Consumer Price Index (CPI), even though future social security COLA's may occasionally be calculated on wage, rather than price increases. On July 1, 1983, to offset the impact of the COLA delay, the Federal maximum monthly benefit was increased by $20 per month for individuals and $30 per month for couples. This one-time increase in SSI benefits is expected to cost $3.7 billion in fiscal years 1983–88.

As mentioned previously, mandatory passthrough provisions for States providing mandatory supplements were modified by the new law. States will be required only to pass through the increase in SSI benefits that would have occurred in July 1983 ($9.70 for individuals; $14.60 for couples), had the one-time increase in the payment standard not been made. To prevent States from reducing payment levels significantly, the legislation requires them to maintain the combined Federal-State benefit levels of March 1983.

Paralleling the income disregard for energy assistance authorized in 1982, the 1983 amendments included a temporary provision to disregard from countable income in-kind support and maintenance donated by private, nonprofit organizations, if the support was provided on the basis of need. Essentially, this provision allows voluntary service organizations the opportunity to privately assist SSI beneficiaries, without causing a decrease in the recipient's SSI benefits. This provision expires on September 30, 1984.

The legislation liberalizes the eligibility restrictions placed upon the homeless who temporarily reside in emergency shelters. In the past, any resident of a public institution (exclusive of publicly operated community care facilities serving 16 people or fewer) was ineligible for SSI during any full month of institutionalization. The new provision allows otherwise eligible homeless residents of emergency shelters SSI benefits for up to 3 months in any year.

Finally, the legislation requires SSA to conduct an SSI alert which will consist of a major effort in the first half of 1984 to notify all low-income, aged social security recipients of the existence and availability of SSI. Additionally, informational material on SSI is to be included in mailings sent to all potential OASDHI recipients.

### 2. Employment and Rehabilitation

The Social Security Disability Amendments of 1980 (Public Law 96–265) included changes that were meant to encourage SSI recipients to seek and engage in employment. The relevant provisions, which became section 1619 of the Social Security Act, were designed to lessen the substantial disincentives to work in SSI. They include: (1) Special monthly benefits, as well as medicaid eligibility, will continue for disabled recipients who have completed the 9-month trial work period and continue to receive earnings in excess of SSI income limits; (2) impairment-related work expenses (e.g., medication, attendant care, special equipment) can now be deducted from countable income; and (3) money earned in sheltered workshops is now treated as earned, rather than unearned income for the purposes of calculating benefits.

The law limited these provisions to a temporary, 3-year trial period that expired on December 31, 1983. Legislation to extend or make permanent the section 1619 provisions is incorporated in both S. 476 and H.R. 4170, bills to comprehensively reform the continuing disability review process. When it became clear that neither of these bills would be enacted before the provisions were to expire, Senator Dole introduced an amendment to H.R. 3391 that would have extended the work disincentive provisions through December 31, 1986. On November 18, the last day of the session, this legislation was passed by the Senate unanimously. In the last hours before adjournment, however, the House failed to accept Senator Dole's amendment.

Though definitive statistics are unavailable, it is estimated that between 200 and 300 people receive special SSI benefits and 5,000 to 6,000 recipients take advantage of extended medicaid benefits. On the basis of waiver authority provided in the quality assurance control provisions of title XVI, SSA is continuing special benefits to participants despite the expiration date, for the month of January 1984. If legislation to extend or make permanent the work disincentive provisions is not enacted in the early part of 1984, participants in the special programs will be forced to discontinue employment, or lose SSI benefits altogether.

The relatively low level of utilization of these special benefits offered by the 1980 amendments appears to be a product of widespread unawareness of the existence of the provisions. Amidst the ceaseless flow of new operating procedures disseminated to SSA district offices, the section 1619 provisions seem to have been lost to local claims representatives. The message that serious employment will not automatically terminate eligibility for SSI, and often more importantly, medicaid eligibility, seems to have not reached the SSI disabled population.

SSA is currently in the design stage of a large project examining the utility of "transitional employment," a rehabilitation strategy designed specifically for the severely disabled. SSA is funding a number of demonstration projects, which they will evaluate for their effectiveness in rehabilitating extremely disabled SSI recipients in relation to conventional rehabilitation practices. Essentially, transitional employment involves placing individuals in a competitive work environment, where special supervisors assist the trainees in adjusting to an actual work setting. This procedure is substantially different from the techniques employed by State rehabilitation agencies, which handle most SSI disability cases. Transitional employment has been a rehabilitation strategy for a considerable period of time; however, private providers of this kind of rehabilitation are not reimbursed for their services by the Federal Government. The purpose of SSA's experiment is to evaluate whether transitional employment can be usefully employed to rehabilitate SSI beneficiaries, and worthy of Federal funding.

### 3. Continuing Disability Investigations

The 1980 amendments to the Social Security Act, as applied to the SSI program, provide for the disability status of recipients to be reviewed at least once every 3 years, but with longer intervals between reviews for those considered permanently disabled.

The program of continuing disability investigations aroused widespread congressional concern as evidence mounted concerning: (1) The heavy workload imposed on State agencies resulting from the high volume of reviews; and (2) the quality of the decisions being rendered at the initial level of review, about two-thirds of which were reversed when individuals appealed their denials to an administrative law judge (ALJ). A full discussion of this issue can be found in this volume in the social security disability section.

In late 1982, Congress enacted H.R. 7093 (Public Law 97-455), which continued payment of social security disability benefits through the ALJ stage for people terminated between the date of enactment and October 1, 1983 (subject to recovery if the termination decision is upheld). This "aid-paid-pending" provision was extended through December 7, 1983 by H.R. 4101 (Public Law 98-118). A further extension was passed unanimously in the Senate on November 18, 1983, the final day before adjournment of the first session, but was not voted upon in the House. Currently "aid-paid-pending" is not a provision that affects SSI recipients. SSI beneficiaries terminated from the rolls bypass the reconsideration level, and appeal their case straight to the ALJ stage. By virtue of rights to due process, required by *Goldberg* v. *Kelly,* benefits are guaranteed to SSI recipients through this appeal process.

However, Public Law 97-455 also provides that if, as a result of a continuing disability investigation, it is determined that an individual is not entitled to title II disability benefits, any reconsideration of that determination may be made only after opportunity for a face-to-face evidentiary hearing. Such hearings must begin no later than January 1, 1984. The administration has indicated that it intends to apply this requirement to SSI determinations also. Though definitive regulations have not been proposed, it appears as though SSA will assume the face-to-face hearing at the reconsideration level satisfies the due process requirements of *Goldberg* v. *Kelly,* and benefits to SSI recipients through the ALJ stage will be suspended, unless legislation is enacted stipulating their provision.

### 4. COLLECTION OF OVERPAYMENTS

The SSI statute authorizes the Secretary of HHS to recover SSI overpayments by adjusting future payments, or by recovery from the recipient. Overpayments may be waived if the individual is without fault and if recovery would defeat the purpose of the program, or be against equity or good conscience, or the amount to be recovered is so small as to impede efficient or effective administration.

Overpayments are more likely to occur in SSI than in other social security programs because SSI is a means-tested program and it must regularly adjust benefits to account for changes in individual income and resources. Most SSI debt is the product of common payment errors and is routinely collected where possible by adjusting future checks. In fiscal year 1982, $472 million in SSI debt was created. Concurrently, SSA cleared $334 million in SSI debt; $290 million was collected and $44 million was waived. At the beginning of fiscal year 1983 there remained $1.1 billion in outstanding SSI debt.

Beginning in 1981, SSA launched an initiative to increase their collection of SSI overpayments as part of a major governmentwide effort by the Reagan administration to improve Federal debt management. SSA's "debt collection action plan," released in June 1981, included four basic strategies: (a) The reallocation of district office personnel and resources to debt collection activities; (b) the submission of legislation and issuance of new regulations and operating procedures to expand SSA's authority to collect overpayments and to create incentives to speed recovery; (c) the use of private debt collection agencies; and (d) the creation of debt reduction objectives and methods of measuring productivity.

In late 1981 and early 1982 SSA began to implement a number of these debt collection strategies. Special debt management teams were created in the district offices, memos were issued emphasizing rapid recovery rather than waiver or write off, and specific regional collection quotas and performance measures were set in place.

Several administrative initiatives were taken by SSA in 1981 to increase recoupments. Operating instructions were revised to replace the previous policy of withholding no more than 25 percent of a monthly check with a policy of withholding 100 percent of subsequent checks until the overpayment is recouped. Overpayment notices were rewritten to instill in beneficiaries a greater sense of urgency about repayment. Training in debt collection used materials produced by private debt collectors to teach district office personnel how to "bring in maximum cash within a minimum amount of time." In January 1982, SSA made public plans, later withdrawn in the wake of public criticism, to use private debt collection agencies to collect overpayment.

While SSA was stepping up its effort to collect overpayments, the Congress made it clear, in passing the Debt Collection Act of 1982 (Public Law 97-365) that social security debt should not be pursued as aggressively as other types of debt owed to the Federal Government. An amendment to the bill specifically exempted payments under the Social Security Act from provisions expanding the authority of Federal agencies to obtain information needed to pursue debtors and from referral to private debt collectors. The exemption was based on an understanding in the Congress that legally entitled beneficiaries who receive erroneous payments have a different kind of debt than those who borrow money from the Government.

Two other SSA debt collection initiatives encountered difficulties in 1982 and 1983. In 1982, the administration included in the fiscal year 1983 budget a proposal to give SSA authority to recover SSI overpayments from benefits payable under other SSA administered programs. Although this proposal was never acted on by Congress, the Social Security Administration instituted an administrative procedure to obtain voluntary agreements with beneficiaries authorizing SSA to recover SSI overpayments from title II (OASDI) benefits. In *Ellender* v. *Heckler*, plaintiffs were successful in enjoining the administration from using these notices, alleging that cross-program recovery is contrary to the statutory prohibition against the assignment of benefits and alleging that the notices used were in violation of due process by not informing individuals of their procedural rights to reconsideration and waiver of overpayments.

SSA was also blocked in an effort to improve the identification of SSI overpayments by obtaining IRS individual taxpayer information on resources. In September 1983, a Federal appeals court ruled that consent forms sent in May 1982 to SSI recipients to authorize the IRS to disclose taxpayer information were misleading and coercive.

Proposed rules SSA issued in February 1983 to limit recipients rights to waiver were also held up, and as yet have not been issued as final regulations. Since 1981, SSA has pursued a policy of limiting waivers of recovery in SSI. This change in policy has been reflected in SSA statistics: Prior to 1981, SSA waived between 40 and 50 percent of all SSI overpayments; by fiscal year 1982, SSA was waiving only 13 percent of SSI overpayments. The proposed rules issued in February 1983 were designed to further limit the granting of waivers by restricting the recipient's right to a waiver to the first 60 days after original notification of the overpayment—currently there is no time limit on a waiver request—and by standardizing the definition of "need" employed in determining whether a waiver is justified. Public criticism of the rules delayed further action, and SSA had yet to withdraw the proposed rules or issue final rules.

### 5. PROGNOSIS FOR 1984

In 1984, the major congressional activity relating to SSI will probably be consideration of proposals to comprehensively reform the continuing eligibility reviews of title II and SSI disability beneficiaries. It is unlikely there will be any major efforts to reduce benefits or limit eligibility in SSI in 1984. It is not impossible, however, that legislation addressing technical and administrative problems in SSI might receive serious congressional attention.

# Chapter 9

# FOOD STAMPS

## OVERVIEW

The food stamp program was created in 1964 to increase the food purchasing power of low-income households. Since its inception, the program has been of enormous benefit in meeting the basic needs of these households and older Americans in particular. In 1983, the cost of the food stamp program (including the nutritional assistance block grant that replaced food stamps in Puerto Rico during 1982) was nearly $12.8 billion. This was almost $1.5 billion more than annual food stamp spending in 1981 and 1982, despite recent legislation restricting eligibility benefits. Greatly increased unemployment expanded the eligible population and pushed costs about 13 percent above their 1981–82 level. For 1984, Congress has appropriated $11.7 billion to fund food stamp benefits (and Puerto Rico's block grant). In doing this, it is relying on projections of an improved economy to keep costs below their 1983 level.

In early 1983, President Reagan's fiscal year 1984 budget request assumed savings of some $1 billion from the enactment of several proposed program changes. However, Congress did not take up comprehensive food stamp legislation or enact further cuts in 1983. Instead, it enacted 1984 appropriations at a level assumed to be adequate to finance the program under present law.

## A. ELDERLY PARTICIPATION

Several legislative changes have been made to the food stamp program over the last few years. The major change affecting the elderly has been the elimination of the purchase requirement (EPR) in the Food Stamp Act of 1977. Prior to implementation of this act, most households were required to pay cash for their stamps. The value of the stamps they received was greater than the purchase price and the benefit of the program was derived from that difference.

Many eligible households were unable to take advantage of the program because they had difficulty acquiring and accumulating the cash required to obtain stamps. In addition, some households were reluctant to exchange their scarce cash resources to obtain food stamp "coupons." Federal studies indicated that only about 40 percent of all eligible older persons participated in the program. Since elimination of the purchase requirement, program participation by households headed by the elderly increased by 32 percent from February 1978 to April 1979. The most recent data available from the Department of Agriculture indicates that participation by households headed by an elderly individual has increased by 42 percent. Over 9 percent of the program's 20.6 million participants in August 1981 were 60 years of age or older.

## B. CONGRESSIONAL ACTION

### 1. BACKGROUND

The Federal Government establishes food stamp program eligibility rules and benefit amounts. For households with elderly members, income eligibility limits correspond roughly to the annual adjusted Federal poverty levels but can be substantially higher if a household has heavy expenses for shelter, dependent care, or medical care. As with income eligibility, benefit levels vary according to household size and the extent to which a household has unusual expenses. Each participating household's monthly food stamp allotment is determined by reducing the maximum allotment to which it would be entitled if it had no countable income by 30 percent of any countable income.[1] Maximum monthly allotments are calculated based on the cost of purchasing food using the Department of Agriculture's "thrifty food plan" estimates of the cost of a nutritionally adequate low-cost diet. These amounts are adjusted for household size, food-price changes (each October), and, in some cases, for geographical food-price differences (Alaska, Hawaii, and the territories).[2] Due to recent legislation, maximum allotments reflect only 99 percent of actual "thrifty food plan" costs, rather than the full cost.

In addition to using their food stamps in grocery markets, senior citizens may use them to purchase meals in participating congregate eating facilities such as senior citizen centers, senior-citizen-occupied apartment buildings, some schools serving meals to the elderly, and other public or private nonprofit establishments feeding older Americans. The elderly may also use food stamps to buy prepared meals delivered to their homes by meals-on-wheels and similar organizations.

### 2. FISCAL YEAR 1982 AND 1983 BUDGET CHANGES

In 1981 and 1982, congressional efforts focused on controlling the cost of the food stamp program by restricting eligibility and the growth of benefits. In response to administration calls for lower food stamp spending, Congress enacted in 1981 and 1982: Eligibility revisions affecting nonelderly households, delays in benefit increases, a 1-percent across-the-board reduction in benefits,[3] and certain technical changes such as revision of the rules for rounding off benefit calculations and prorating first-month benefits according to the date of application. By current estimates, these revisions have held food stamp costs about $2.8 billion below what they would have been in 1982 and 1983: $1.5 billion in 1982 and $1.3 billion in 1983. They are expected to hold 1984–85 spending approximately $4.1 billion below what it would have been under pre-1981 law: $2 billion in 1984 and $2.1 billion in 1985. Overall, congressional actions in 1981 and 1982 resulted in savings totaling nearly $7 billion, or 13 percent, for the years 1982–85.

---

[1] In some areas of the country, supplemental security income (SSI) recipients receive their food stamp benefits in cash rather than food stamps.

[2] Under Puerto Rico's nutritional assistance block grant, eligible households receive cash benefits roughly 10 to 20 percent smaller than food stamp allotments granted in the regular food stamp program. Food stamps in Puerto Rico were replaced by this block grant program in July 1982.

[3] This was done by adjusting each October's inflation indexing of benefits to reflect only 99 percent of the full cost of purchasing a diet using the Agriculture Department's "thrifty food plan."

The bulk of these savings were achieved through delaying benefit increases and making them smaller than would otherwise have been the case, along with various technical changes, not by direct reduction of food stamp benefits already in the hands of recipients. However, some 1 million nonelderly recipients did lose eligibility and some recipients experienced benefit cuts due to changes in how earnings and shelter costs are treated and due to technical changes affecting benefit computations.

### 3. Fiscal Year 1984 Proposals

Although President Reagan's fiscal year 1984 budget, presented to Congress in early 1983, recommended further food stamp budget cuts, Congress rejected any substantial changes in the food stamp program in 1983. The additional revisions proposed by the administration would have produced a $1 billion gross savings to the Federal Government in 1984 and somewhat larger savings in later years.

The rejected proposals were of two types. Approximately half the savings were to be achieved by shifting some benefit costs to the States. Under present law, all benefit costs are paid by the Federal Government; under the administration's proposals, States would have been responsible for a substantial share of the cost of any erroneously issued benefits. The rest of the proposed savings were to come primarily from simplifying and standardizing benefit calculations. Direct adjustment for excessively high shelter expenses associated with earned income, through the use of special "deductions" that reduced countable income (and thus increased benefits), was to be ended and replaced with standard dollar amounts not tied directly to shelter expenses or the amount of earned income. Elderly households would have borne a substantial share of the benefit losses occasioned by the elimination of a special adjustment for heavy shelter expenses since, under present law, that adjustment is more liberal for elderly and disabled households.

Rather than consider comprehensive food stamp legislation in 1983, Congress chose to focus its attention on the appropriations process and to make a few minor changes in law in response to particular administrative problems that arose in 1983. In its first food stamp action of 1983, Congress enacted a last-minute $1.2 billion supplemental appropriation needed to fully fund benefits through the end of fiscal year 1983 (Public Law 98–63). This extra money was required because of increased program enrollment caused by increased unemployment.

In the fall of 1983, Congress acted twice through continuing appropriations resolutions (Public Law 98–107 and Public Law 98–151), to insure food stamp funding for fiscal year 1984. As of January 1, 1984, fiscal year 1984 appropriations stood at $11.7 billion (including $825 million for Puerto Rico's nutritional assistance block grant), a significant decrease from the $12.8 billion appropriated for 1983. This appropriations level assumes a substantial improvement in the economy. However, if late 1983 economic projections turn out to be overly optimistic, it might be necessary to consider a supplemental appropriation during 1984 in order to provide money for unreduced benefits through the end of fiscal 1984 (as was done in 1983).

Finally, Congress acted to make four minor changes in food stamp law in response to particular problems that arose during 1983. At Puerto Rico's request, Congress lifted a restriction in the law governing its nutritional assistance block grant program in Public Law 98-204. The requirement that aid granted under the block grant not be in the form of cash, beginning in October 1983, was effectively repealed until further consideration of the issue, thereby allowing Puerto Rico to continue this method of assistance. Congress also opened up food stamp eligibility to residents of a limited group of publicly sponsored alcoholic treatment programs (in Public Law 98-107), and, in Public Law 98-204, loosened administrative requirements for the monthly reporting of income by nonelderly households and the use of prior, rather than current month's in determining eligibility and benefits; and expanded the types of information States may use in verifying recipients' income.

## C. OTHER ISSUES

Several other issues arose during 1983 that may have an effect on congressional consideration of food stamp legislation in 1984, over and above the proper level of funding for the program and any new administration requests for budget reductions.

As the result of a change in law enacted in 1982, States have made significant changes in the "standard utility allowances" used in adjusting food stamp benefits to take into account high shelter expenses. In effect, most States have been required to significantly lower the standard dollar amounts they will "disregard" as income to many food stamp recipients due to high shelter expenses. As a result, more recipient income is counted, and benefits reduced. This may lead Congress to reopen the question of how to adjust benefits for shelter expenses.

Present law requires that any July increase in social security or related benefits not be considered income to food stamp recipients until the normal October adjustment of food stamp benefits, thereby aiming at coordination of the two inflation adjustment mechanisms. However, in 1983, Congress postponed social security adjustments until January, ending this coordination. As a result, food stamp recipients receiving a social security increase in January 1984 will experience a cut of roughly 30 cents in food stamps for each extra dollar in social security.

In addition to the administration's 1983 proposals, other legislative initiatives advanced in 1983 and still pending before Congress would allow States to choose a block grant of Federal funding to run their own nutritional assistance program rather than food stamps, restore the food stamp purchase requirement eliminated in 1977, and liberalize food stamp law for elderly and disabled persons who live with others.

Other recommendations that may affect congressional action on food stamps in 1984 include those made by the President's Private Sector Survey on Cost Control in Federal Government, a proposed rewrite of the food stamp regulations scheduled for sometime in 1984, and the recommendations of the President's Task Force on Food Assistance scheduled for January 1984.

The Private Sector Survey recommendations concentrate on: (1) Revising the method by which food stamp allotments are calculated and thereby reducing benefits to small households and increasing them for larger households; and (2) counting child nutrition benefits received by food stamp families as income.

In late 1983, the Agriculture Department announced that it was working on a major rewrite of food stamp regulations to be proposed in 1984. Early indications are that the revised rules will significantly change the way in which recipient-supplied information is verified, increasing responsibilities of recipients.

The Food Assistance Task Force final recommendations are expected to include both liberalized and more restrictive rules for food aid programs including food stamps. The draft of the final report released on January 9 stated that a lack of up-to-date data regarding hunger in America makes it impossible to assess whether the problem has grown worse over the last few years. However, the task force did call for revisions in the food assistance programs.

In main, the report recommended that Congress make participation in existing Federal food assistance programs optional for the States by establishing a food assistance block grant. It also recommended several changes in the food stamp program which would affect the elderly. These included: Restoring the food stamp allotment to 100 percent of the cost of the thrifty food plan (it currently meets 99 percent of the cost); revising residency requirements to make it possible for the homeless to qualify for benefits; raising the asset limits to $3,500 for elderly households; simplification of application procedures which are judged too complex and time consuming; and providing cash benefits to elderly in lieu of coupons to provide greater flexibility in obtaining food.

Legislative proposals to restore some of the benefit reductions legislated in 1981 and 1982 are expected early in the second session of the 98th Congress. The 1984 budget resolution left room, in a "contingency fund," for up to $450 million in new food stamp spending, if Congress chooses to use it.

# Part III

# HEALTH

## HEALTH STATUS OF THE ELDERLY

The majority of Americans of all ages generally view themselves as being in good health. According to the 1981 National Health Interview Survey, 8 of 10 elderly persons describe their own health as good or excellent when asked to compare their health with others of their own age. Self-perception of health varies dramatically with variables such as health, education, sex, race, marital status and, income. In 1981, 42 percent of elderly persons with incomes of $25,000 or more rated their health as excellent in comparison with people their age, while only 25 percent of persons with incomes of $7,000 or less did the same.

After age 65, there is a tendency for women to report their health more positively than males; older whites tend to report more favorable health than older blacks; older persons who have never married report better health than those who are married, divorced, widowed, or separated; persons 65 years or older with higher education are more likely to view their health favorably than those with less education and older persons who are currently employed report the most favorable health status of all older persons falling in other employment categories.

## MORTALITY TRENDS

More people are living longer than ever before in our history.

Death rates for both men and women fell considerably over the last four decades. Key reasons for this decrease are: Elimination of infectious childhood disease, improved health care and nutrition, and reduction in child-bearing mortality. The mortality rate for men is greater than for women at all age groups over 65 years of age.

From 1940 to 1980, the death rates for the elderly decreased by 27 percent to 53 deaths per 1,000 in the population. Some of the change in mortality for elderly persons is obscured by the aging of the elderly population. Analysis of trends in mortality is enhanced by examining age-adjusted death rates which are relatively free from the distortions associated with a changing age composition. The age-adjusted death rate for the elderly decreased by 38 percent, 26 percent for males and 48 percent for females, from 1940 to 1980.

The decline in death rates has been particularly striking in the upper age groups. Between 1950 and 1978, annual death rates for women 85 and older declined by nearly one-third. Death rates for men 85 and older declined by about 20 percent. These decreases in mortality have been primarily due to declining death rates for heart disease and stroke. Rates for cancer deaths, on the other hand, have been rising. Heart disease remains the major cause of death among persons 65 and older, however, accounting for over 40 percent of deaths in the 65 to 84 age group and almost 50 percent of deaths for those over the age of 85.

Although there is considerable controversy over whether declining death rates have significantly raised the limits of longevity, they have resulted in a substantial increase in the number of persons reaching the age of 75 and over. Should declining death rates for the elderly continue at the present rate, it is likely that the number of elderly persons by the year 2000 will exceed current projections.

## CAUSES OF DEATH

Today, in the United States, three out of four persons 65 years or older die from heart disease, cancer, and stroke alone. Heart disease is the No. 1 cause of death for all age groups—including the elderly—far outranking any other cause of death. However, over the last decade deaths due to cardiovascular diseases and stroke decreased, while those due to cancer (malignant neoplasms) increased. Hypothetically, if heart disease were eliminated, an estimated 11.8 years would be added to life expectancy at birth and 11.4 years at age 65. The elimination of cancer would add 2.5 years at birth and 1.4 years at age 65. It is expected that death rates due to these causes will be reduced over the next couple of decades due to the amount of research being carried out on these two major illnesses.

## CHRONIC CONDITIONS

Chronic conditions are problems of aging. They are relatively rare in younger age groups, but by middle age, chronic diseases account for the majority of disabilities.

This pattern of chronic morbidity has changed in the past 80 years. At the turn of the century acute conditions predominated. But, today, chronic conditions account for over half of the country's disability days for the elderly population.

Chronic conditions are responsible for a large portion of the Nation's expenditures for health. However, most older persons are able to live independently in spite of these conditions. According to the 1981 data from the National Center for Health Statistics' National Health Interview Survey, about 18 percent of older persons report that they can no longer carry on normal activities because of chronic conditions. Although the need for help with basic activities of daily living (such as bathing, toileting, dressing, and eating) increases with advancing age, the vast majority of individuals continue to be able to perform these activities of daily living independently.

For the 1981 population of men and women age 65 and over, the leading chronic conditions were arthritis and hypertensive disease.

Many elderly people are hospitalized for chronic conditions rather than illnesses leading to death. Digestive conditions, circulatory conditions, and neoplasms are leading causes of hospitalizations among the elderly. Most visits to physicians by older persons are for conditions such as circulatory problems, arthritis, and respiratory conditions.

## NURSING HOME CARE

The last two decades have seen a substantial increase in the number of nursing home residents. In 1963, there were 505,000 individuals residing in nursing homes. By the time of the last survey of the nursing home population in 1977, the number had grown to 1.3 million. (Estimates for the 65-plus nursing home population for 1980 are 1.2 million persons.)

According to projections based on current estimates for the nursing home population and U.S. Census Bureau population projections, by the turn of the century, this number is expected to increase 80 percent to 2.2 million, and by the year 2050, more than triple to 5.4 million. Ninety percent of all nursing home residents are 65 years and older.

Although, the percentage of elderly persons in nursing homes is small, 4.7 percent, the likelihood of residing in a nursing home increases with age. According to the 1977 Nursing Home Survey, only 1 out of every 100 persons in the 65 to 74 age group is in a nursing home on a given day. However, this number increases to 7 out of 100 persons in the 75 to 84 age group and more than 1 out of every 5 persons in the 85-plus population.

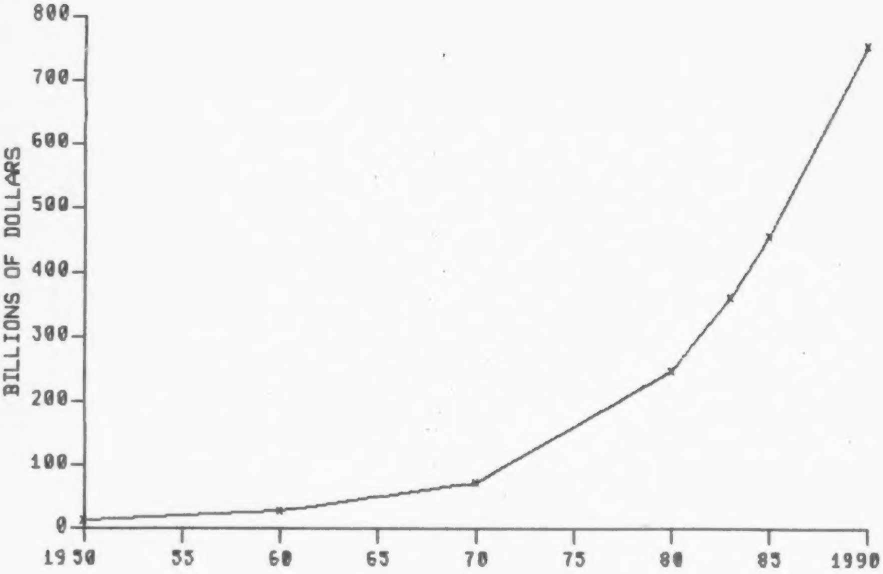
A number of factors have contributed to the tremendous increase in the nursing home population between 1963 and 1980 including: (1) Growth in the numbers of elderly, especially those over 75; (2) rapid "deinstitutionalization" of residents from mental institutions; (3) the nature of the health care reimbursement system which encourages institutional care; and (4) the lack of support of government or private insurance to cover community-based alternatives. Assuming current trends, nursing home utilization is predicted to be the fastest growing segment of the health care system in the next two decades.

## NATIONAL HEALTH CARE EXPENDITURES

Health care expenditures continue to consume an increasing share of the national economy and to grow at rates far exceeding growth rates of either the gross national product (GNP) or the Consumer Price Index (CPI). In 1965, health care consumed only $1 out of every $20 spent nationally; by 1982, the share of the economy dedicated to health care exceeded $1 out of every $10. In 1983, the health expenditure share increased again, to more than 11 percent of the GNP. Projected national and per capita health expenditures through 1990 are shown in charts 1 and 2. These high growth rates have a substantial impact on both the public and private sectors. In 1983, for example, American businesses paid $77 billion for health insurance—more than the total paid by businesses in dividends to shareholders.

## CHART 1

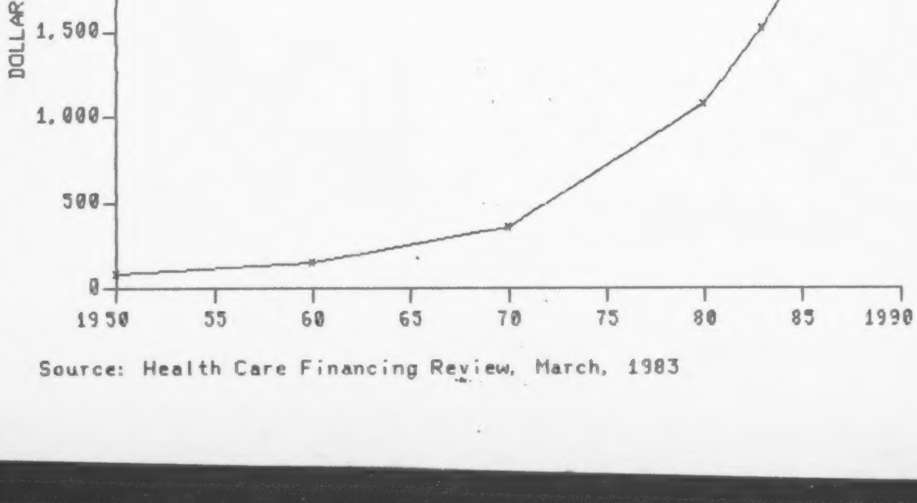
### NATIONAL HEALTH EXPENDITURES



Source: Health Care Financing Review, March, 1983

## CHART 2

### NATIONAL HEALTH EXPENDITURES PER CAPITA



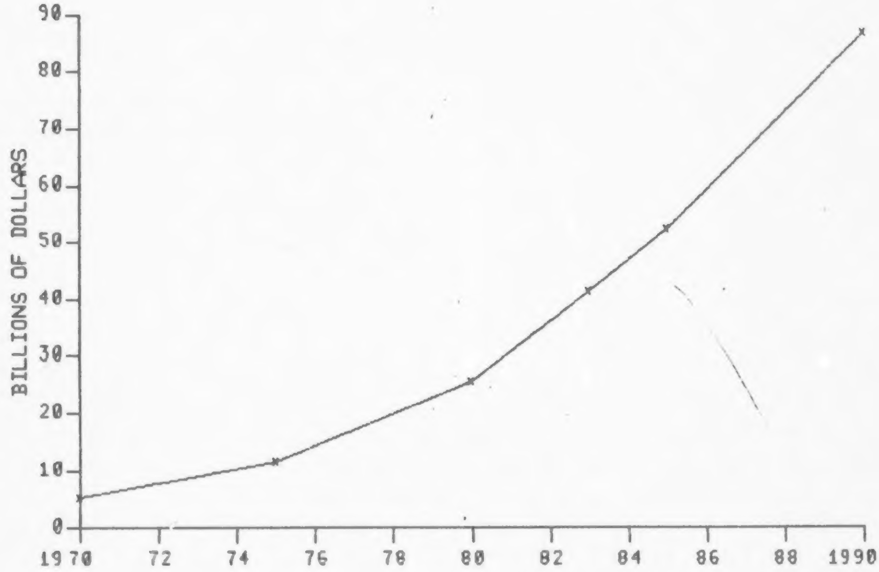
Source: Health Care Financing Review, March, 1983

## MEDICARE EXPENDITURES

Medicare expenditures—the major Federal program financing health care for the elderly have been growing dramatically in absolute dollars, in relation to the Federal budget, and in comparison with the national economy. Over the past decade the medicare share of Federal budget has almost doubled—from less than 4 percent in 1973 to nearly 7 percent in 1983. During that same period, medicare expenditures increased from less than $10 billion in 1973 to over $57 billion in 1983. This increase, averaging growth rate of almost 18 percent annually, is more than 2½ times the rate of inflation, and one-third more than the growth rate for national expenditures. Even with the reduced annual growth rates of under 15 percent projected for the medicare program from 1983 through 1988, medicare's share of total Federal outlays is expected to reach $1 in $10 in the Federal budget for 1988. Estimated outlays under medicare parts A and B through 1990 are shown in charts 3 and 4. The bulk of medicare dollars go for care of enrollees who are clearly ill; 12 percent of elderly enrollees accounted for 78 percent of the medicare dollars spent in 1981.

CHART 3

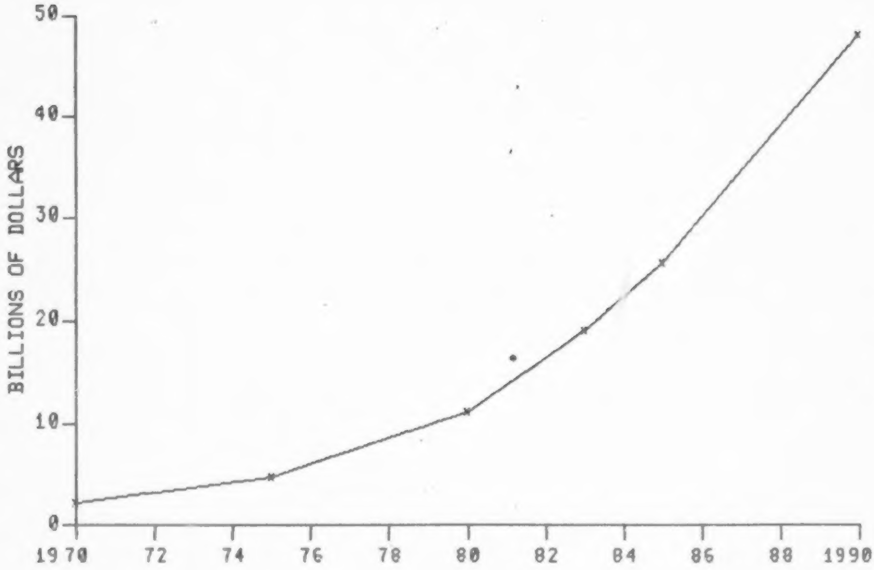
MEDICARE HOSPITAL INSURANCE TRUST FUND
(Outlays, Calendar years)



Source: Health Care Financing Review, March, 1983

CHART 4

MEDICARE SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND
(Outlays, Calendar Years)



Source: Health Care Financing Review, March, 1983

## MEDICAID EXPENDITURES

It is estimated that 3.5 million of the 22.6 million medicaid recipients are elderly. Program expenditures are clearly weighted toward institutional services, especially long-term care. Estimated medicaid costs in fiscal year 1983 are $35.5 billion—$19.3 billion Federal, and $16.2 billion State.

Federal and State medicaid expenditures for nursing home care equalled $13 billion in 1982. The medicaid program has become one of the largest programs that most States fund and the most rapidly increasing item in most State budgets.

## CAUSES OF HEALTH CARE COST INCREASES

The major factors driving the cost of medicare also drive the cost of the entire national health care system. Hospital services represent over two-thirds of medicare expenditures and about half of national expenditures for personal health care. The major reason for the rapid increase in hospital prices nationally and in the medicare program is the rapid increase in the cost per day of hospital services, not the increased aging of the population or increased admissions. Inpatient hospital expenses increased at an average annual rate of nearly 15 percent from 1970 through 1983. The hospital market basket, or hospital input prices, accounted for 60 percent of the increase, increased intensity for 23 percent, and increased admissions for 15 percent. Increases in intensity—hospital cost increases not attributed to inflation or increased use—has grown as a factor contributing to inflationary hospital costs. It accounts for 4.6 percent of the 18 percent increase since 1981, compared to an average 3 percent from 1970 to 1980. Hospital prices in excess of inflation and increased intensity of service per admission accounted for four-fifths of the increased costs. And, although the hospital utilization rates of persons aged 65 and over have not increased substantially, the number of medicare enrollees over 65 increased from 1967 to 1978 at a rate double that of the Nation as a whole, resulting in correspondingly increased hospitalizations.

The major factor affecting the increase in physician expenditures is the inflation in physician's fees. Since 1950, physician fees have risen more rapidly than the economy as a whole. In 1981, for example, about half of the 16 percent increase was attributable to price changes. The remaining portion was attributable to factors such as increased intensity of services per enrollee, increased use of specialists, changes in billing practices, and more expensive procedures. Increased visits to physicians by medicare beneficiaries has not been a factor in cost increases; the number of visits to physicians per year by those over 65 has changed very little from 1970 to 1981.

## OUT-OF-POCKET COSTS

Despite increases in medicare's costs, the elderly pay a substantial portion of their total health care bill out of pocket and spend an increasing proportion of their incomes on health care.

Americans 65 and over have significant out-of-pocket health costs; they paid nearly one-third of their medical bill ($1,182 per capita in 1981). Even excluding long-term care, noninstitutionalized aged enrollees paid about 20 percent of their medical bill out of pocket. The actual dollar amount of out-of-pocket expenses is about the same for all income groups, but its impact varies dramatically. The poor and near poor paid 14 percent of their income out of pocket for health care in 1977, while those in the highest income group (four times poverty or more) spent on average only 1 percent of income for out-of-pocket health care expenses.

While increases in cost sharing is one method for reducing the Federal health budget, proposals must be evaluated in the context of the already substantial cost sharing that takes place currently and the differential impact that cost sharing has on the oldest, poorest, and sickest individuals. Cost sharing relating to utilization falls hardest on the sickest and those with lower incomes, particularly those covered only by medicare. Older, poorer, chronically ill, and terminally ill enrollees are most likely to be high users of care.

## 1983 FEDERAL ACTIONS IN HEALTH FOR THE ELDERLY

Health programs continued to be a target for budgetary reductions in 1983, particularly the Federal health entitlement programs—medicare and medicaid. Most significantly, the Social Security Amendments of 1983 (Public Law 98-21) included a major change in the method of medicare reimbursement to hospitals. The change from a cost-based reimbursement to price-based reimbursement will be phased in over 3 years. Medicare's new prospective payment system is designed to reduce the rate of increase in medicare outlays for hospital services, and to change the financial incentives for hospitals in favor of greater efficiency. Congress also took steps to increase funding for the National Institutes of Health, including $3.5 million for the establishment of five specialized research centers for research on Alzheimer's disease and related disorders.

## Chapter 10

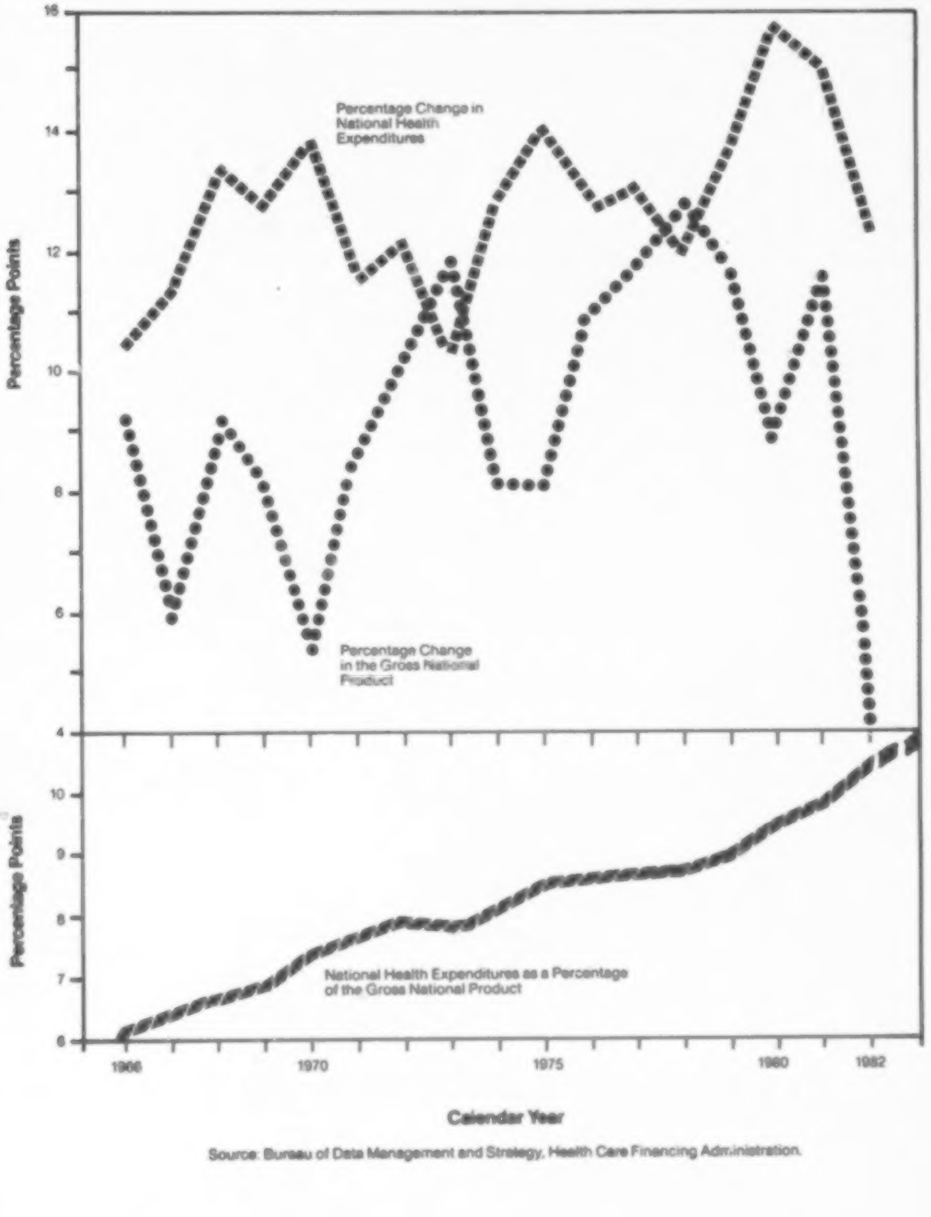
# HEALTH CARE EXPENDITURES

Health expenditures in 1983 in all sectors—hospital services, physician services, and nursing home care—continued to increase at rates that are nearly triple the rate of inflation in the general economy. The Federal Government took a major step in 1983 to control its health expenditures by reforming the medicare reimbursement method for hospital services, but there were no major achievements in reducing rates of increase elsewhere in the health sector.

Health care costs continued, in 1982 and 1983, to consume a growing percentage of the gross national product, increasing from 9.8 percent in 1981 to 10.5 percent in 1982 and 11.1 percent in 1983, as shown in chart 1.

CHART 1

**National Health Expenditures and Gross National Product: Growth and Relative Sizes, 1966–1982**



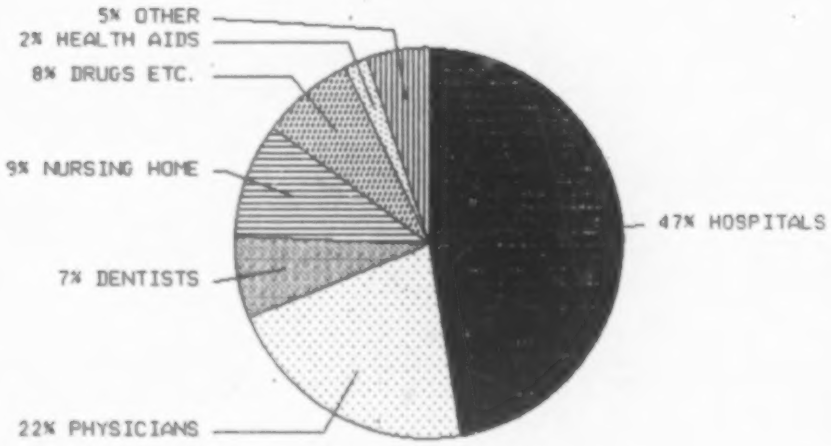
Source: Bureau of Data Management and Strategy, Health Care Financing Administration.

The rate of increase in health expenditures declined slightly in 1982 and 1983, largely due to the decline in the rate of inflation and the impact of the economic recession. The growth rate for 1982 declined to 12.5 percent, and for 1983, to an estimated 11 percent, after increases of 15.8 percent in 1980 and 15.1 percent in 1981.[1] The decline in the growth rate for health expenditures was much less than the decline in the Consumer Price Index (CPI), which fell dramatically from 8.9 percent in 1981, to 3.9 percent in 1982, and 3.8 percent in 1983.

Expenditures increased from $287 billion in 1981, to $322 billion in 1982, and reached an estimated $357 billion in 1983. (Due to staff reductions in 1983 in the Bureau of Data Management and Strategy of the Health Care Financing Administration, complete national health expenditures tables for 1983 are not available at this time.) A depiction of where our national health dollar comes from and where it goes can be seen in charts 2 and 3 and tables 1, 2, and 3.

CHART 2

PROJECTIONS OF NATIONAL HEALTH EXPENDITURES
BY TYPE OF EXPENDITURE
1983



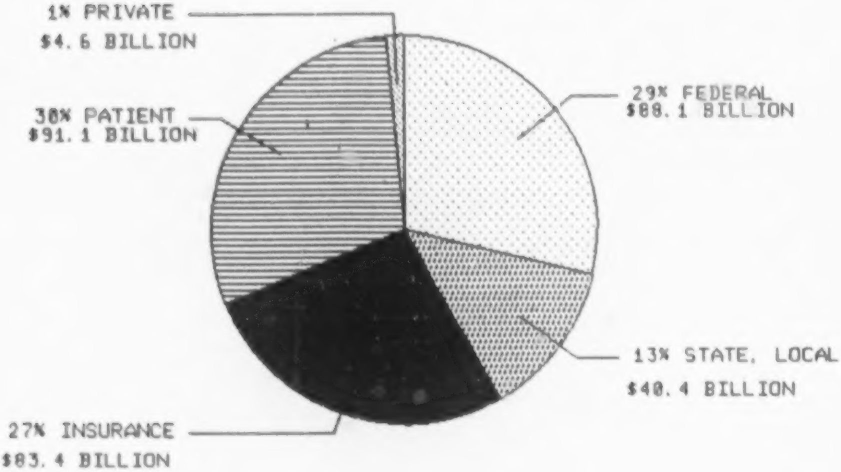
SOURCE: HEALTH CARE FINANCING ADMINISTRATION, UNPUBLISHED

---

[1] U.S. Dept. of Health and Human Services, Health Care Financing Administration, Office of Research and Demonstrations. HCFA Pub. No. 03146, September 1982.

## CHART 3

PROJECTIONS OF NATIONAL HEALTH EXPENDITURES
BY CHANNEL OF PAYMENT, CALENDAR YEAR 1983



SOURCE: HEALTH CARE FINANCING ADMINISTRATION, UNPUBLISHED

TABLE 1.—PROJECTIONS OF NATIONAL HEALTH EXPENDITURES BY TYPE OF EXPENDITURE AND BY CHANNEL OF PAYMENT, CALENDAR YEAR 1982 [1]

[In billions]

| | Total | Private | | | | | Public | | |
|---|---|---|---|---|---|---|---|---|---|
| | | Total | Consumer | | | Other | Total | Federal | State and local |
| | | | Total | Patient direct | Health insurance | | | | |
| Total | $321.4 | $185.1 | $174.6 | $91.1 | $83.4 | $10.6 | $136.3 | $93.5 | $42.8 |
| Health services and supplies | 307.7 | 179.2 | 174.6 | 91.1 | 83.4 | 4.6 | 128.5 | 88.1 | 40.4 |
| Personal health care | 287.0 | 170.8 | 166.8 | 91.1 | 75.6 | 4.0 | 116.2 | 84.2 | 32.0 |
| Hospital care | 135.9 | 63.0 | 61.0 | 15.9 | 45.1 | 2.0 | 72.9 | 55.1 | 17.8 |
| Physicians' services | 61.8 | 44.6 | 44.6 | 23.5 | 21.0 | 0 | 17.2 | 13.5 | 3.6 |
| Dentists' services | 19.5 | 18.7 | 18.7 | 13.7 | 5.0 | 0 | .8 | .4 | .3 |
| Other professional services | 7.1 | 5.4 | 5.3 | 4.1 | 1.3 | .1 | 1.7 | 1.3 | .3 |
| Drugs and medical sundries | 22.4 | 20.4 | 20.4 | 17.8 | 2.6 | 0 | 2.0 | 1.0 | 1.0 |
| Eyeglasses and appliances | 5.5 | 4.7 | 4.7 | 4.4 | .3 | 0 | .8 | .7 | .1 |
| Nursing home care | 27.1 | 12.2 | 12.0 | 11.7 | .3 | .2 | 14.9 | 8.1 | 6.9 |
| Other health services | 7.8 | 1.7 | 0 | 0 | 0 | 1.7 | 6.0 | 4.1 | 1.9 |
| Program administration and net cost of insurance | 13.1 | 8.4 | 7.8 | 0 | 7.8 | .6 | 4.7 | 2.6 | 2.1 |
| Government public health activities | 7.6 | 0 | 0 | 0 | 0 | 0 | 7.6 | 1.3 | 6.3 |
| Research and construction of medical facilities | 13.8 | 5.9 | 0 | 0 | 0 | 6.0 | 7.8 | 5.3 | 2.4 |
| Research | 5.6 | .3 | 0 | 0 | 0 | .4 | 5.3 | 4.7 | .5 |
| Construction | 8.2 | 5.6 | 0 | 0 | 0 | 5.6 | 2.5 | .6 | 1.9 |

[1] This is a provisional estimate for 1982 based on partial year data available as of autumn 1982 (final estimates will be available in September 1983).

Source: Health Care Financing Administration, unpublished.

TABLE 2.—NATIONAL HEALTH EXPENDITURES BY SOURCE OF FUNDS, CALENDAR YEAR 1983 PROJECTION (BASED ON DATA THROUGH MID-1983)

[In millions]

|  | Total (2+3) (1) | Patient direct payments (2) | Third-party payments (4+5+6) (3) | Private health insurance (4) | Philanthropy and industrial inplant (5) | Total government (7+10) (6) | Federal (8+9) (7) | Medicare (8) | Other Federal (9) | State and local government (10) |
|---|---|---|---|---|---|---|---|---|---|---|
| National health expenditures | $356,505 | $99,267 | $257,238 | $94,045 | $12,134 | $151,059 | $103,801 | $59,789 | $44,012 | $47,258 |
| Health services and supplies | 341,114 | 99,267 | 241,848 | 94,045 | 5,285 | 142,518 | 97,853 | 59,789 | 38,064 | 44,665 |
| Personal health care | 316,755 | 99,267 | 217,488 | 84,590 | 4,588 | 128,310 | 93,790 | 58,412 | 35,378 | 34,520 |

TABLE 3.—NATIONAL HEALTH EXPENDITURES BY TYPE OF SERVICE CALENDAR YEAR 1983 PROJECTION (BASED ON DATA THROUGH 1983)

[In millions]

| | Total | Medicare | Medicaid |
|---|---|---|---|
| National health expenditures | $356,505 | $59,789 | |
| Health services and supplies | 341,114 | 59,789 | |
| Personal health care | 316,755 | 58,412 | $18,623 |
| Hospital | 149,872 | 41,032 | 6,886 |
| Physicians' services | 68,799 | 13,585 | 1,838 |
| Dentists' services | 21,597 | | 360 |
| Other professional services | 7,919 | 1,560 | 227 |
| Drugs and sundries | 24,370 | | 1,002 |
| Eyeglasses and appliances | 6,203 | 825 | NA |
| Nursing home care | 29,779 | 533 | 7,445 |
| Other personal care | 8,215 | 877 | 865 |
| Government public health activity | 9,486 | | |
| Prepayment and administration | 14,874 | 1,378 | |
| Research and construction | 15,391 | | |
| Research | 6,202 | | |
| Construction | 9,189 | | |

Note: Estimates for tables 2 and 3 were compiled in December 1983. Medicare estimates are on a national health accounts, calendar year basis.
Source: Health Care Financing Administration, unpublished.

## A. PERSONAL HEALTH CARE EXPENDITURES

Personal health care accounts for approximately nine-tenths of total health care expenditures. Spending for personal health care increased at a rate of 12.5 percent during 1982—from $255 billion in 1981 to $287 billion in 1982. This is significantly less than the 16.2 percent increase for 1981. For 1983, the rate of increase is projected to decline again slightly, to 10.4 percent over 1982, reaching an estimated $317 billion. It should be noted, however, that even these growth rates are nearly triple the increase in the CPI.

Personal health care is divided into a number of different goods and services.

### 1. HOSPITAL SERVICES

Hospital services are the largest personal health care expenditures, accounting for 46.4 percent of the total. Hospital expenditures for 1983 were an estimated $150 billion, an increase of 10.7 percent over the 1982 expenditures of $135.5 billion.[2]

In 1981, price inflation in goods and services that hospitals purchase accounted for over 70 percent of the growth of expenditures, according to an analysis by the Health Care Financing Administration. Increased use of hospitals accounted for only 12 percent of the increase. The remaining residual increase was largely due to new technology and increases in intensity of care, i.e., increased services per person.[3] The Federal Government funded 41.3 percent of spending for hospital care in 1981, private health insurance paid for 33.4 percent, State and local governments paid for 13.1 percent, and patients paid slightly over 10 percent of the cost of hospital care directly out of pocket.[4]

---

[2] Ibid., p. 7.
[3] Ibid., pp. 7–8.
[4] Ibid., p. 7.

## 2. PHYSICIAN SERVICES

Physician services accounted for 19.3 percent of all personal health care expenditures in 1983, for an estimated total of $69 billion, an 11.7 percent increase from the $61.8 billion spent in 1982. This rate of growth is just 1 percent less than the 12.7 percent rate of growth in 1982.[5] Public funds accounted for over one-fourth of the total spending for physician services as of 1982. Private insurance and direct payments to physicians split the remainder almost evenly.[6]

Price inflation and intensity of services are responsible for most of the growth in expenditures. The decline in the rate of increase of expenditures in 1983 is largely attributable to decreased inflation and possible decreased utilization. Over the past decade, the number of office visits has not had much effect on the growth of spending; this is because the total number and the per capita number of office visits have changed very little.[7] According to the National Center for Health Statistics (NCHS) Health Interview Survey, visits to physicians by the noninstitutionalized population remained relatively constant between 1971 to 1980, at around 1 billion visits per year. However, the intensity of services has increased. For example, in the last 10 years, the number of surgical operations grew from 7 to 8½ per 100 persons. The volume of tests in independent clinical labs has also been increasing at a 15-percent annual rate in recent years.

## 3. NURSING HOME CARE

In 1982, expenditures for nursing home care were $27.3 billion, a 12.9-percent increase from the $24 billion spent in 1981.[8] This is a 4.5-percent decline from the 17.4 percent increase in expenditures in 1981, but still three times the rate of increase in the CPI. For 1983, the increase is an estimated 9.1 percent over 1982, to an estimated $30 billion, which is more than twice the CPI of 3.8 percent for 1983.

Nursing home expenditures in 1982 equaled 9.4 percent of all personal health care expenditures; this is projected to decrease in 1983 to 8.4 percent. Public programs pay for a little more than one-half of the total nursing home bill, and patients pay for most of the rest directly out of pocket. Of public expenditures, medicare paid only 3 percent, while medicaid paid for approximately 90 percent.[9]

Excluding intermediate care facilities for the mentally retarded, spending for nursing home care doubled between 1976 and 1981, from $11 to $22 billion. Input prices during that same period increased at an annual rate of 9 percent, while nursing home days of care increased only 3 percent annually. Input prices grew even faster in 1981 at 10 percent, but the growth in the number of days of care increased more slowly than the previous 5-year average.[10]

---

[5] Ibid., p. 7.

[6] Ibid., p. 7.

[7] Ibid., p. 7.

[8] Ibid., p. 8.

[9] U.S. Dept. of Health and Human Services. Health Care Financing Administration. Unpublished data.

[10] U.S. Dept. of Health and Human Services. Health Care Financing Administration. Office of Research and Demonstrations. HCFA Pub. No. 03116, September 1982. p. 8.

The major factors in the growth of nursing home spending include rapid expansion of medicaid-funded intermediate care facilities for the mentally retarded, as well as the growth in prices and days of care in other types of nursing home settings. As with all health services, part of the decline in rate of growth of expenditures in 1982 and 1983 is due to the declining general rate of inflation. However, a substantial portion of the decline of the rate of expenditure growth for nursing homes is probably the result of Federal and State budgetary cutbacks in medicaid expenditures in 1981.

### 4. Drugs and Medical Sundries

Outpatient prescription and over-the-counter drugs and medical sundries accounted for about 7.8 percent of total personal health care spending in 1982 and 6.7 percent in 1983, a substantial decrease from this category's 12-percent share of personal health care spending in 1965.[11] In 1982, drugs and medical sundries accounted for $22.4 billion, an increase of 6.6 percent over the $21 billion spent in 1981. For 1983, an increase of 8.7 percent is projected over 1982, with an estimated $24.4 billion in expenditures. This is slightly lower than the average annual increase of 9.3 percent between 1965 to 1981.

### 5. Other Personal Health Care Goods and Services

Other personal health care goods and services include dental services and services of other health professionals (including most home health agencies), eyeglasses, and orthopedic appliances. Expenditures in this category were $39.9 billion in 1982, 13.9 percent of personal health care spending. Expenditures increased 9 percent in 1982 compared to 13.7 percent in 1981. The principal expenditure in this category is dental services which was $19.5 billion in 1982 and $21.6 billion in 1983.

## B. PERSONAL HEALTH CARE EXPENDITURES BY AGE GROUP

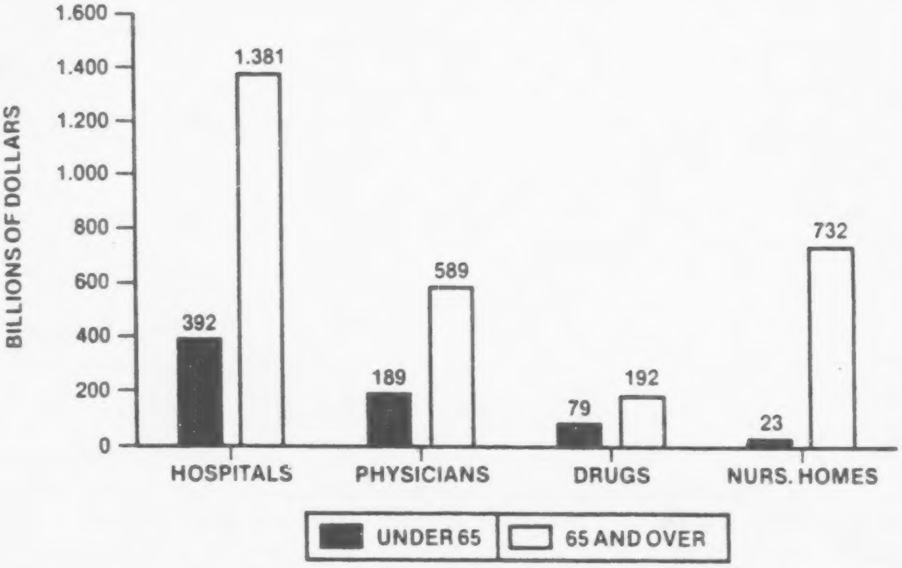
The 65 and over population consumes a larger share of healthcare services than does the younger segment of the population. In 1981, the latest year that spending estimates by age group are available, those over age 65 accounted for 11 percent of the population and 33 percent of total personal health care expenditures. In 1981, per capita personal health care expenditures were estimated to be $828 for those under age 65 and $3,140 for those age 65 and older. Excluding nursing home care, estimated 1981 per capita personal health care expenditures for those over age 64 would still be three times that of those under age 65. (See chart 4 and table 4 below.)

---

[11] Ibid., p. 9.

## CHART 4

### PER CAPITA PERSONAL HEALTH CARE EXPENDITURES BY SELECTED SERVICES PERSONS UNDER AGE 65 AND 65 YEARS AND OLDER 1981



SOURCE: Health Care Financing Administration, unpublished, reported in U.S. Senate Special Committee on Aging: 1982, Volume One.

TABLE 4.—PERSONAL HEALTH CARE EXPENDITURES: ALL AGES, UNDER AGE 65, AGE 65 AND OVER, TOTAL AND PER CAPITA AMOUNTS BY TYPE OF EXPENDITURE AND BY CHANNEL OF PAYMENT, CALENDAR YEAR 1981 [1]

| Type of expenditure | All ages | | | Under age 65 | | | Age 65 and over | | |
|---|---|---|---|---|---|---|---|---|---|
| | Total | Private | Public | Total | Private | Public | Total | Private | Public |
| | Aggregate amount (in billions) | | | | | | | | |
| Total | $225.0 | $152.2 | $102.9 | $171.8 | $122.1 | $49.7 | $83.2 | $30.0 | $53.2 |
| Hospital care | 118.0 | 53.9 | 64.1 | 81.4 | 48.6 | 32.8 | 36.6 | 5.3 | 31.3 |
| Physicians' services | 54.8 | 39.8 | 15.0 | 39.2 | 33.2 | 6.0 | 15.6 | 6.6 | 9.0 |
| Dentists' services | 17.3 | 16.6 | .7 | 14.9 | 14.2 | .6 | 2.4 | 2.3 | .1 |
| Other professional services | 6.4 | 5.0 | 1.4 | 4.4 | 3.8 | .6 | 2.0 | 1.2 | .8 |
| Drugs and medical sundries | 21.4 | 19.5 | 1.9 | 16.3 | 15.3 | 1.0 | 5.1 | 4.2 | .9 |
| Eyeglasses and appliances | 5.7 | 5.1 | .7 | 4.7 | 4.5 | .3 | 1.0 | .6 | .4 |
| Nursing home care | 24.2 | 10.6 | 13.6 | 4.8 | 1.0 | 3.8 | 19.4 | 9.6 | 9.8 |
| Other health services | 7.2 | 1.6 | 5.8 | 6.2 | 1.5 | 4.9 | 1.0 | .1 | .9 |
| | Per capita amount | | | | | | | | |
| Total | 1,090 | 650 | 440 | 828 | 588 | 240 | 3,140 | 1,132 | 2,008 |

TABLE 4.—PERSONAL HEALTH CARE EXPENDITURES: ALL AGES, UNDER AGE 65, AGE 65 AND OVER, TOTAL AND PER CAPITA AMOUNTS BY TYPE OF EXPENDITURE AND BY CHANNEL OF PAYMENT, CALENDAR YEAR 1981 [1]—Continued

| Type of expenditure | All ages | | | Under age 65 | | | Age 65 and over | | |
|---|---|---|---|---|---|---|---|---|---|
| | Total | Private | Public | Total | Private | Public | Total | Private | Public |
| Hospital care | 504 | 230 | 274 | 392 | 234 | 158 | 1,381 | 200 | 1,181 |
| Physicians' services | 234 | 170 | 64 | 189 | 160 | 29 | 589 | 249 | 340 |
| Dentists' services | 74 | 71 | 3 | 72 | 69 | 3 | 91 | 87 | 4 |
| Other professional services | 27 | 21 | 6 | 21 | 18 | 3 | 75 | 45 | 30 |
| Drugs and medical sundries | 91 | 83 | 8 | 79 | 74 | 5 | 192 | 158 | 34 |
| Eyeglasses and appliances | 24 | 21 | 3 | 23 | 22 | 1 | 38 | 23 | 15 |
| Nursing home care | 103 | 45 | 58 | 23 | 5 | 18 | 732 | 362 | 370 |
| Other health services | 31 | 7 | 24 | 30 | 7 | 23 | 38 | 4 | 34 |

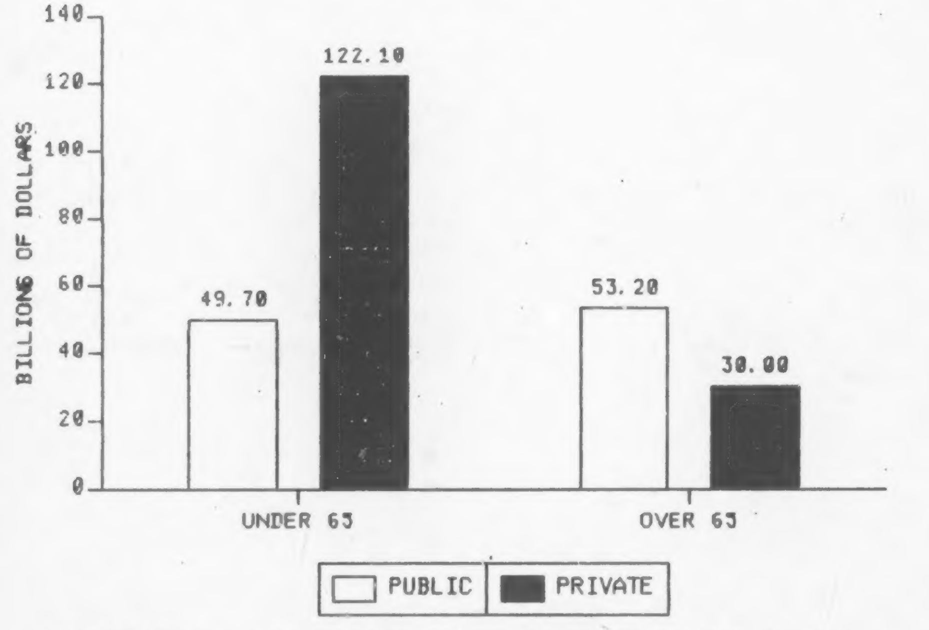
[1] This is a provisional estimate for 1981. Final estimates will be available in June 1983.

Source: Health Care Financing Administration, unpublished.

As can be seen in chart 5, the public/private ratio of source of payment for those under age 65 and those over 65 is almost exactly reversed. This difference is mainly attributable to the dominance of private, employer-paid, insurance for those under 65 and medicare for those over 65.

CHART 5

AGGREGATE PERSONAL HEALTH CARE EXPENDITURES
UNDER AGE 65 AND 65 AND OVER, CALENDAR YEAR 1981



SOURCE: HEALTH CARE FINANCING ADMINISTRATION, UNPUBLISHED

The following table, however, shows that public payments are the major source of payment for those 65 and over for hospital services, but not necessarily other services. For example, 49.5 percent of nursing home services expenditures are paid for by private sources, as are the great majority of expenditures for dental services and outpatient drugs.

TABLE 5.—AMOUNT OF PERSONAL HEALTH CARE EXPENDITURES FOR PERSONS AGE 65 AND OVER BY TYPE OF EXPENDITURE AND CHANNEL OF PAYMENT FOR CALENDAR YEAR 1981 [1]

[In billions]

| Type of expenditure | Total | Private | Public | | | |
|---|---|---|---|---|---|---|
| | | | Total | Medicare | Medicaid | Other public |
| Total | $83.2 | $30.0 | $53.2 | $37.7 | $11.4 | $4.1 |
| Hospital care | 36.6 | 5.3 | 31.3 | 27.1 | 1.3 | 2.9 |
| Physicians' services | 15.6 | 6.6 | 9.0 | 8.5 | .4 | .1 |
| Dentists' services | 2.4 | 2.3 | .1 | | .1 | (2) |
| Other professional services | 2.0 | 1.2 | .8 | .7 | .1 | (2) |
| Drugs and medical sundries | 5.1 | 4.2 | .9 | | .8 | .1 |
| Eyeglasses and appliances | 1.0 | .6 | .4 | .4 | | (2) |
| Nursing home care | 19.4 | 9.6 | 9.8 | .4 | 8.7 | .7 |
| Other health services | 1.0 | .1 | .9 | .5 | .1 | .3 |

[1] This is a provisional estimate. Final estimates will be available in June 1983.

[2] Less than $50 million.

Source: Health Care Financing Administration, unpublished.

The major categories of personal health care expenditures for those age 65 and over are as follows:

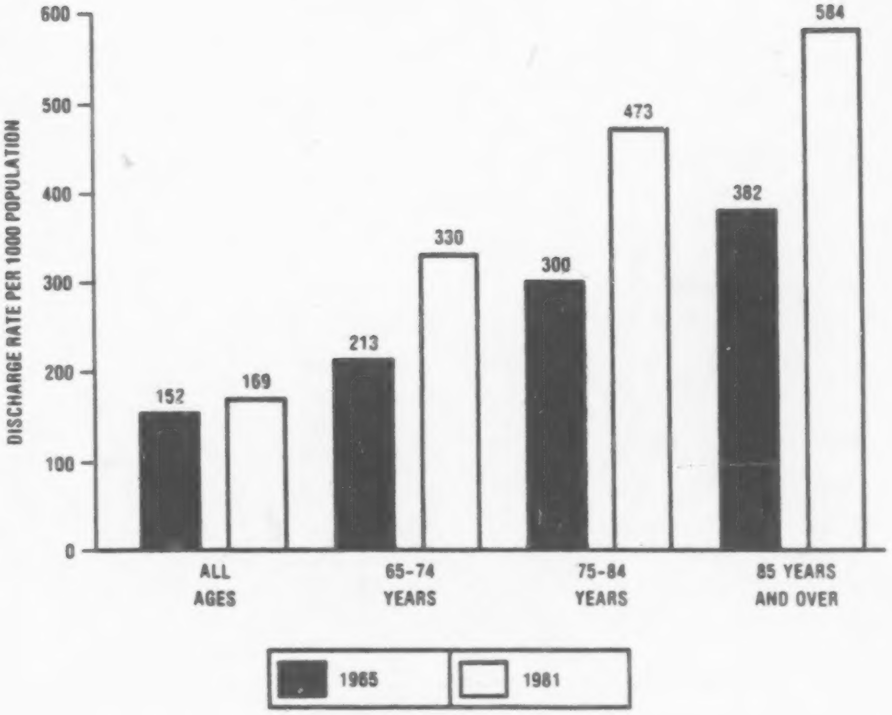
### 1. Hospital Care

Hospital services are the largest personal health expenditure of this group, accounting for 44 percent of the total. Personal health care expenditures for hospital care for those age 65 and over equaled $36.6 billion in 1981, 42 percent of total expenditures, 85.5 percent of which was paid for by public sources of funds. Medicare alone paid for 74 percent of the total hospital expenditures for those over the age of 65.

The use of short-stay hospitals by elderly persons has increased since the year the medicare program was enacted. For example, discharge rates from hospitals for persons between the ages of 65 and 74 increased 55 percent between 1965, the year medicaid was enacted, and 1981 (chart 6).

## CHART 6

**USE OF SHORT-STAY NON-FEDERAL HOSPITALS
SINCE MEDICARE WAS ENACTED
1965 AND 1981**



SOURCE: National Center for Health Statistics, The Need for Long Term Care: A Chartbook of the Federal Council on the Aging and The 1981 National Hospital Discharge Survey reported in Development in Aging, Volume 1, 1982

Part of this increase is due to the aging of the population, since hospital usage increases with age. Discharge rates for persons over 85 years of age are 23 percent higher than for persons between 75 and 84 years of age and are 77 percent higher than for the 65 to 74 year age group.[12]

In 1980, persons over age 65, representing 11 percent of the population, used 34.1 percent of short-stay hospital days. The population over 75, only 4.4 percent of the population, used 9.1 percent of short-stay hospital days.

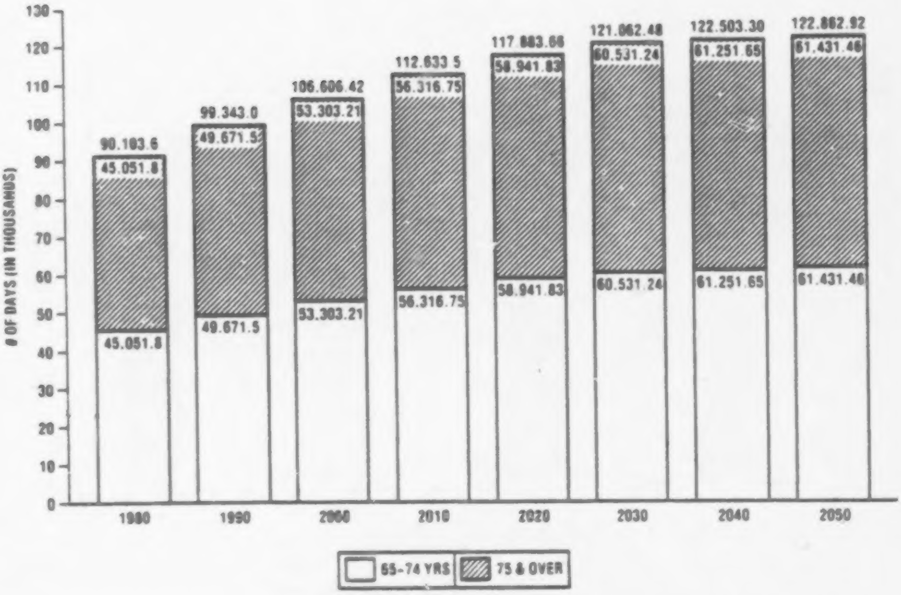
The aging of the population will result in an older hospital patient population and, unless there are major breakthroughs in health care and disease prevention, increased need for availability of hospital care (chart 7).

---

[12] Ibid., p. 9.

## CHART 7

## NUMBER AND DISTRIBUTION OF SHORT STAY HOSPITAL DAYS PERSONS 65 YEARS AND OLDER BY AGE GROUP ACTUAL AND PROJECTED 1980-2050



SOURCE: National Center for Health Statistics, Office of Analysis and Epidemiology and U.S. Bureau of the Census, Population Estimates and Projections, Series P-25, No. 922, October 1982 and Preliminary Estimates of the Population of the United States, by Age, Sex, and Race: 1970 to 1981, Series P-25, No. 917

### 2. PHYSICIAN SERVICES

Total personal health care expenditures for physician services for those over 65 in 1981 equaled $15.6 billion, or 18.8 percent of total expenditures, 57.3 percent of which was paid by public sources. Medicare alone paid for 54.5 percent of total physician expenditures for those age 65 and over.

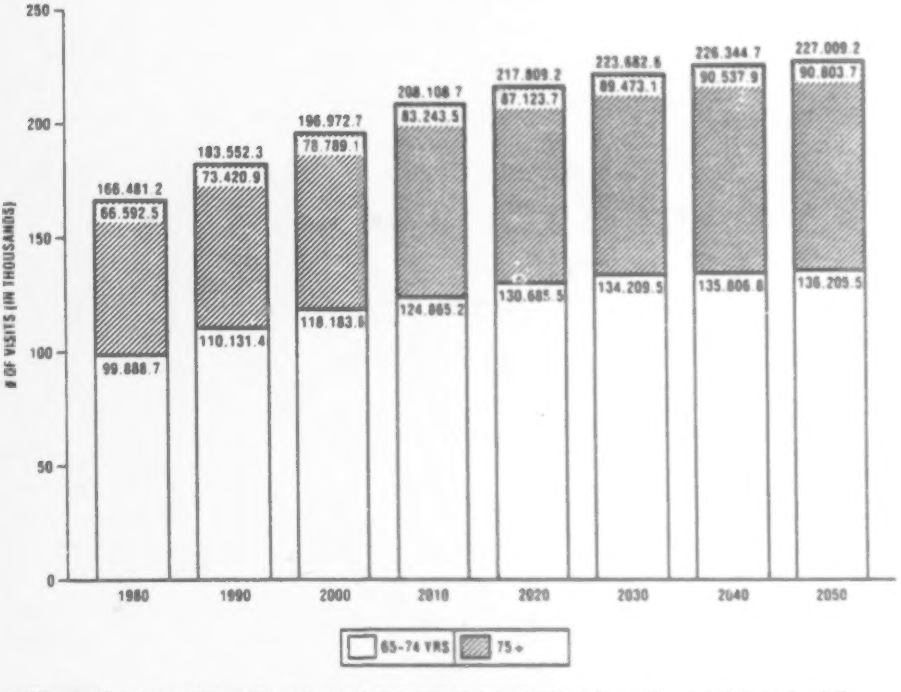
Utilization of physician services increases with age. In 1981, persons aged 45 to 54 averaged 4.7 doctor visits a year, while persons between ages 65 to 74 averaged 6.3 visits. And, according to results of the 1981 Health Interview Survey, while 71.8 percent of persons in the 45 to 54 age group reported that they had seen a doctor in the last year, 78.3 percent of persons 65 to 74 and 83.3 percent of persons 75 years or older reported using this service. Since the enactment of medicare, the average number of physician contacts and the percentage of persons 65 and over reporting that they had seen a physician in the last year has increased significantly, particularly for persons with low incomes.

The disparity between elderly and young populations in the use of physician visits is not as great as the disparity in the use of short-stay hospital care. In 1980, persons under 65, 88.9 percent of the population, accounted for 84.9 percent of physician visits in 1980, while those 65 or over, 11 percent of the population, accounted for 15 percent of visits.[13]

The aging of the population will create a greater demand for physician care (chart 8). According to projections based on 1980 physician visit rates and U.S. Census Bureau population projections, the need for physician visits will increase by 18 percent (over 30 million visits) by the year 2000, by 30 percent (over 50 million visits) by 2020, and by over 36 percent (over 60 million visits) by 2050.

CHART 8

**NUMBER AND DISTRIBUTION OF PHYSICIAN VISITS**
**PERSONS 65 YEARS AND OLDER BY AGE GROUP**
**ACTUAL AND PROJECTED**
**1980-2050**



SOURCE: National Center for Health Statistics Office of Analysis and Epidemiology and U.S. Bureau of the Census. Population Estimates and Projections, Series P-25 No. 922, October 1982 and Preliminary Estimates of the Population of the United States, by Age, Sex, and Race: 1970 to 1981, Series P-25, No. 917

## 3. NURSING HOME CARE

Total personal health care expenditures for nursing home services for those over age 65 in 1981 equaled $19.4 billion or 23.3 percent of total expenditures, 50.5 percent of which was paid for by public sources. Medicare alone only paid for 2 percent of total nursing home expenditures for those over age 65. Medicaid, which accounted for 87 percent of public nursing home expenditures for those over age 65, paid 44.7 percent of total nursing home expenditures. Of the 49.5 percent of nursing home expenditures paid for by private sources, almost all was paid directly out of pocket due to a lack of private insurance coverage of nursing home services. Eighty percent of all nursing home expenditures are for those age 65 and over.

---

[13] U.S. Department of Health and Human Services. Health Care Financing Administration. Office of Research and Demonstrations. HCFA Pub. No. 03146, September 1982, p. 12.

### 4. Other Professional Services

Dentist services and other professional services, which include home health, accounted for $4.4 billion or 5.3 percent of total personal health care expenditures for those age 65 and over, 20 percent of which was paid for by public sources. Medicare provides no coverage for dental services, 96 percent of which were paid for solely by private funds. Expenditures for dental services accounted for 13 percent of total personal health care expenditures of those 65 years and over.

### 5. Eyeglasses and Appliances

Total personal health care expenditures for those age 65 and over for eyeglasses and other appliances were $1 billion in 1981, or 1.2 percent of total expenditures, 40 percent of which were covered by medicare alone with neglible contributions from other public sources of payments. Most of medicare's coverage was for medical appliances since medicare provides no coverage for corrective eyeglasses.

## C. ACTIONS TO REDUCE PERSONAL HEALTH CARE EXPENDITURES

### 1. All-Payer Systems

Several States have addressed the problem of rising hospital costs by applying a hospital prospective payment system to all payers for hospital care in the State, including private insurers, medicaid, and medicare (through waivers from the medicare program). Although the method of payment varies considerably from State to State, all-payer hospital payment systems have been established in the States of Maryland, Massachusetts, New Jersey, and New York.

Many believe that unless a hospital payment system applies to all payers, the opportunity exists for hospitals to "cost shift" by increasing their charges to payers not under the payment system to make up for any reduced payments from payers who are under the system. Others believe that hospital payment systems which apply to all payers reduce incentives to create innovative alternatives to existing hospital payment systems since price competition is eliminated under the all-payer system.

Legislation was introduced in Congress in 1984 (by Senator Kennedy and by Representatives Gephardt, Shannon, and Mikulski) which would require the application of a prospective payment system to all payers for health care. The program would encourage

States to establish their own hospital cost control systems; in the absence of State systems, the Federal Government would operate all-payer systems. In addition, the legislation establishing the medicare prospective payment system (Public Law 98-21) authorizes the Secretary of Health and Human Services to waive medicare's payment system for States that wish to establish their own hospital payment systems applying to all payers, including medicare. Proposals to contain health care costs through an all-payer approach, either initiated voluntarily by the States or mandated by Federal law, are likely to be considered in 1984.

### 2. COMPETITIVE APPROACHES

As an alternative to a regulatory approach for containing health care costs, a number of market-oriented strategies have been developed to create incentives to make the existing health care financing and delivery system operate more like a properly functioning economic market. These proposals, sometimes called the competition approach to health care financing and delivery, aim to promote increased competition among the providers of health care services, as well as wider consumer choice and greater price sensitivity when selecting health benefits protection. The competitive initiatives usually contain proposals for:

—Development of competitive medical plans (such as health maintenance organizations) and other entities that attempt to control health spending by placing the suppliers of services at financial risk for the provision of unnecessary care. Others suggest the development of "preferred provider organizations" (PPO's), which involve agreements between providers and purchasers of services at negotiated or discounted rates. Patients who choose to receive care from providers not on preferred lists pay higher out-of-pocket costs or receive fewer benefits, or both.

—Voucher plans, which are fixed dollar contributions from employers and/or the Government to purchase health benefits protection from the private marketplace. Advocates argue that voucher plans could help to reduce the demand for services, encourage consumers to shop carefully for health benefit coverage, and eventually create competitive pressures on insurers and suppliers to moderate both the prices for and the volume of services provided.

—Tax law changes, which include "caps" or limits on the maximum amount of employer contributions for health benefits. Amounts above the cap would be taxable as personal income to workers. Such changes would reduce the tax subsidies for the purchase of insurance with small or no deductibles and copayments and could, advocates say, help to moderate the demand for services.

Proposals addressing all of the above variations in the competitive approach were introduced in the first session of the 98th Congress. As policymakers search for a method of controlling rising health care costs, it is possible that these competitive approaches will receive further consideration in 1984.

# Chapter 11

# FEDERAL PROGRAMS PROVIDING HEALTH COVERAGE FOR THE ELDERLY

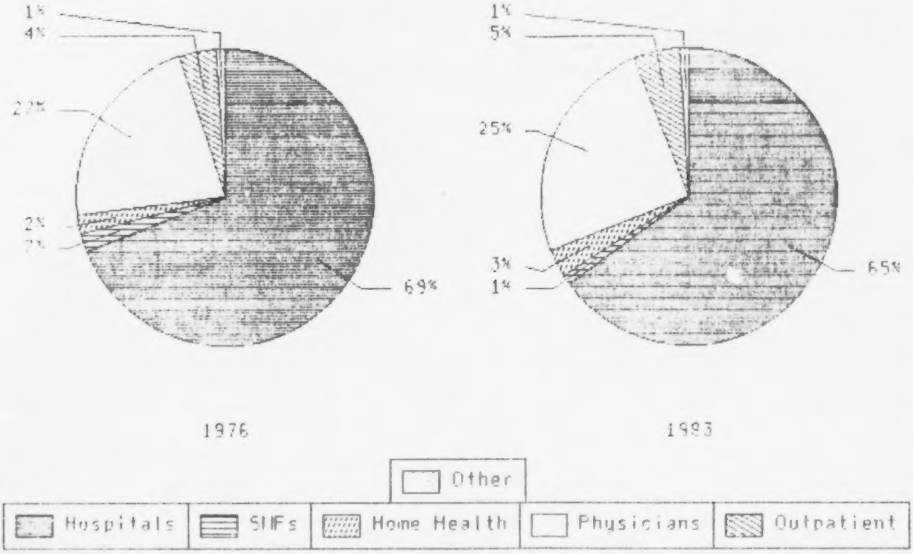
## A. MEDICARE

Medicare was enacted in 1965 as a means of providing protection for the elderly from the costs of health care. There is no question that medicare has, in fact, provided this protection to many older Americans and, in doing so, has become the single largest purchaser of health care in the world. From a program spending $3.2 billion in 1967, it has grown to an estimated $57.4 billion in fiscal year 1983. The costliness of the medicare program in combination with the inadequacy of its present funding structure brought it into the limelight in 1983. A variety of proposals to change hospital insurance trust fund costs and revenues and beneficiary insurance coverage surfaced in 1983, and more reform proposals can be expected to emerge in 1984.

Medicare is comprised of two programs—hospital insurance (HI), which pays for inpatient hospital care, stays in skilled nursing facilities, and home health services; and supplementary medical insurance (SMI), which pays for all other services covered by medicare (principally physician services). In 1983, 26 million aged and 3 million disabled participated in the medicare program. Chart 1 shows where the medicare dollar was spent in 1975 and 1983.

CHART 1

WHERE THE MEDICARE DOLLAR GOES



Source: Health Care Financing Administration, Office of the Actuary

## 1. Medicare's Fiscal Crisis

Growth rates of the medicare program are contributing to a fiscal crisis in the hospital insurance (HI) trust fund which finances part A of medicare. On April 13, 1983, in a hearing on "The Future of Medicare," Dr. Alice M. Rivlin, Director of the Congressional Budget Office (CBO), testified before the Senate Special Committee on Aging:

> Total medicare outlays have been growing at an average annual rate of 17.7 percent since 1970, largely because of rapidly rising medical care costs, and CBO projections suggest continued high growth. This projected growth in outlays threatens the solvency of the hospital insurance trust fund, which is financed almost exclusively by payroll taxes * * * without changes in current law, the HI trust fund would be depleted by 1988 and, by the end of 1995, would have a cumulative deficit of about $300 billion * * *

In November 1983, CBO provided the House Ways and Means Committee with another estimate of the cumulative deficit in the HI trust fund: With stringent limits on hospital payments (market basket plus 1 percent per year increase), the trust fund would remain solvent until 1992 and the cumulative deficit would reach only $93 billion by 1995. Administration actuaries are currently preparing reestimates of the HI balances over the next 20 years, based in part on recently improved economic assumptions. In any case, variations in the estimates only affect the timing of bankruptcy by a few years: Although the fund is currently solvent, in the long run a deficit will occur as long as the earnings that are taxed to provide revenue are projected to grow much more slowly than hospital costs. In the November CBO projection, annual increases in hospital expenditures averaging 12.4 percent from 1985 to 1995, more than 5 percent greater than average increases in tax revenues of about 8 percent per year. Financing in the supplemental medical insurance (SMI) program, in contrast to HI, is based on enrollee premiums and on general revenue appropriations, and solvency is guaranteed by law. However, growth rates of about 16 percent per year in the SMI program constitute an equal threat to our ability to assure that the Federal Government is a prudent purchaser of health care services under this part of medicare as well.

One major medicare reform was effected in 1983—the change from a retrospective, cost-based reimbursement system to a prospective, price-based reimbursement system for hospitals, based on diagnosis related groups (DRG's). This reform is discussed at length in chapter 12, Federal Health Legislation.

### 2. GROWTH OF MEDICARE

The 17.7 percent average annual increase in medicare outlays between 1970 to 1982 has made medicare one of the largest and fastest growing areas of the Federal budget, equaling 7 percent of total Federal outlays in 1982. With the lower projected rates of increase of over 14 percent, medicare's share of total Federal outlays are projectd to reach 10 percent by 1988. This is about three times the annual rate of inflation and one-third more than the growth of national personal health expenditures.

Medicare expenditures increased over 20 percent in calendar years 1980 and 1981.[1] In calendar year 1982, due to medicare savings enacted in 1981 and a decline in inflation rates and in rates of growth of health expenditures in general, the increase in spending dropped to 16.5 percent. For 1983, the growth rate is projected to drop further to 13.8 percent. Although this rate of growth is less than in previous years, the 1983 level still is more than three times the rate of inflation, and 4 percentage points more than the rate of increase of personal health care expenditures for all ages.

According to the Congressional Budget Office, medicare outlays are projected to reach $112 billion by 1988, increasing at an average annual rate of 14.4 percent from 1983 to 1988.

The growth in medicare outlays is attributable to several factors. These include demographic changes, alterations in the mix and intensity of services, and price inflation. An expanded medicare enrollment reflects increases in the number of elderly in the population, improved life expectancy for the elderly, and beginning in 1973, the extension of the program coverage to the disabled (including those with kidney disease). Price inflation, particularly medical care inflation, is the primary factor affecting increased program outlays.

---

[1] U.S. Department of Health and Human Services, Health Care Financing Administration. Health Care Financing Review, U.S. No. 1, Fall 1983. p. 23.

Nationwide, over the 1970–82 period, overall medical care costs rose 165 percent compared with a Consumer Price Index (CPI) increase of 149 percent, physician services costs rose 169 percent, and hospital room charges rose 283 percent. Adjusted expenses per inpatient admission for all persons in community hospitals increased 254 percent from 1970 to 1981. These trends are particularly important since approximately 95 percent of Federal medicare part A expenditures are for hospital care and over 75 percent of Federal medicare part B expenditures are for physician services.

The concern over reducing Federal deficits, in combination with the large share of Federal outlays that medicare represents, has focused Federal attention on reducing medicare's costs. Serious concerns over the revenue shortfalls the HI trust may face as early as the end of this decade have increased pressures to control medicare expenditures.

Congress enacted legislation in the Omnibus Budget Reconciliation Act of 1981 to reduce medicare outlays in fiscal year 1982 by $1.4 billion. Medicare provisions enacted in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) save an estimated $2.7 billion in fiscal year 1983. The hospital prospective payment system (DRG's) enacted as part of the Social Security Amendments of 1983 is required to be "budget neutral" in fiscal year 1984 and fiscal year 1985—that is, the amounts paid under medicare must be the same as they would have been under the previous legislation (TEFRA). The new payment system has the potential for stemming increases in hospital expenses in future years. (For further discussion of the new hospital prospective payment system, see chapter 12.)

### 3. THE HOSPITAL INSURANCE (HI) TRUST FUND

Medicare's HI trust fund faces serious financial problems by the end of this decade. HI revenues come almost exclusively from a portion of the social security payroll tax. In 1984, employers and employees will each contribute 1.3 percent of covered earnings, with the rate scheduled to increase to 1.35 percent in 1985, and 1.45 percent in 1986. Under current legislation, general revenues cannot be used to make up any shortfall between required outlays and trust fund balances.

The financing problems of HI stem from the fact that outlays are determined by required reimbursement to hospitals and other health providers which, under current law, are growing much more rapidly than earnings to which the HI tax is applied. In June 1983, the board of trustees reported that unless Congress acts to increase program revenues or reduce outlays, or some combination thereof, the HI trust fund will be depleted during 1990. Cumulative deficits could exceed $200 billion by 1995, according to the 1983 trustees report.

The trustees of the hospital insurance program also indicated that the tax rates currently specified in the law (including the scheduled 1985 and 1986 increases) would be sufficient, along with interest earnings and assets in the HI trust fund, to support program expenditures and make required loans to the social security retirement and survivors programs only for the next 6 to 7 years.

In order to bring the HI program into close actuarial balance over the next two decades, either outlays will have to be reduced by 30 percent or income increased by 43 percent.

Estimates of the near-term financial condition of the HI trust fund made by the Congressional Budget Office (CBO) in the spring of 1983 were somewhat more pessimistic than those made by administration actuaries. In November 1983, CBO projected depletion of the HI trust fund by the end of the decade (1990 was the most probable year) unless further policy changes are made in the medicare hospital insurance program. The year end balances in the trust fund are projected to decline each year as annual outlays exceed annual income. Deficits would be small at first, but then increase rapidly. By 1995, the annual deficit is projected to be over $60 billion and the cumulative deficit will total more than $250 billion. This projection includes generous annual increases in the hospital payment level.

Beginning in fiscal year 1986, the Secretary of Health and Human Services is given considerable discretion under present law to set hospital payment rates under the HI program. If the Secretary decided to permit the per case payments to increase by 1 percentage point more than the annual rate of increase in hospital input prices (i.e., the prices of goods and services hospitals purchase in the market place), then CBO projects a delay in the date of the trust fund's depletion to sometime in 1992, with a cumulative deficit of only $93 billion in 1995. Large deficits in the fund would still occur, but in lesser annual and cumulative amounts.

The CBO projects that for the 10-year period beginning in 1985 (when most of the recent legislative changes will have been implemented) outlays will grow at a 12.4 percent annual rate while revenues are projected to increase at a 7.9 percent rate. If the economy's performance is worse than projected, HI balances would decline more quickly than in this projection.

### 4. SUPPLEMENTARY MEDICAL INSURANCE (SMI) TRUST FUND

The medicare SMI program, which pays for physician services and related medical services is by definition financially sound, mainly due to its financing structure. SMI revenues are obtained from premiums and general revenues. Although premiums have been falling as a percentage of SMI, from 50 percent at the inception of the program to less than 25 percent in 1983, general revenue financing assures that the fund will be maintained. For the 2-year period beginning January 1, 1984, premiums will be held at a rate equal to 25 percent of the projected actuarial costs of the aged.

The Congressional Budget Office projects that outlays under SMI will increase almost 16 percent annually through 1988. To finance the increase, general revenue financing of the SMI program would have to rise 17 percent annually.

## 5. ACTIONS TO REDUCE HEALTH CARE COST INCREASES IN 1984

### (A) PROPOSED CHANGE

In February 1984, the Medicare Task Force of the Social Security Advisory Council made recommendations for solving the funding crisis of the HI trust fund, including:

—Taxation of employer-provided health insurance.
—Increased Federal excise taxes on alcohol and tobacco.
—Increased age of eligibility for medicare benefits (from age 65 to 67).
—Restructuring of part A and part B benefits and increased premiums.
—Indexed SMI deductible; and
—Development of physician fee schedules and a participating physician system.

In 1984, Congress is expected to begin monitoring the implementation of the new DRG-based prospective payment system. Congress will also be examining various proposals for reducing program outlays, including modifications in physician payments. Restoring solvency to the medicare trust fund could require major changes over the coming decade in benefits, revenues or cost sharing. For example: Reductions in payments to hospitals of more than one-third; reductions in benefits of about one-third of current benefit levels; or increases in payroll taxes to nearly double current rates could be required to insure HI solvency through 1995.

During the first session of the 98th Congress, there was no consideration of any legislative proposals to address the gaps in medicare coverage which still remain, such as lack of coverage for long-term care, preventive services, outpatient drugs, basic dental services, hearing aids and eyeglasses. The major exception to this inattention to coverage gaps is the consideration of various proposals to cover catastrophic care under medicare.

The size and growth of the medicare program in a time of large Federal budget deficits have made the program a target for budgetary cutbacks. Projections for revenue shortfalls in the hospital insurance trust fund by the end of this decade have added pressure to control medicare expenditures. Inevitably, increased beneficiary cost sharing will be among proposals considered to gain revenues and/or reduce the growth of expenditures. Any reforms must be evaluated in the context of the protection provided under the current medicare program, the reasons for its growth, who uses services, and how beneficiaries will be affected by program changes.

### (B) COST SHARING

Increased cost sharing is one method that has been proposed for reducing the Federal medicare budget, but it must be evaluated in light of three major considerations. First, it does not address the greatest problem facing medicare and the entire health care system—the rapid growth in the cost of care. Second, beneficiary cost sharing is already substantial. Third, it falls hardest on those who are sickest and poorest and least able to afford it and may further limit the access of the lower income beneficiary to needed medical care.

There is no doubt that increased cost sharing associated with use of services (deductibles and coinsurance) can somewhat reduce use of both physician visits and hospital admissions. However, use of services contributes little to the growth of medicare and health care costs overall. The main reason for this growth has been the rising cost of treatment. Four-fifths of the increase in hospital expenditures in excess of general inflation from 1971 to 1981 was due to increased hospital prices and intensity of services per case reflecting in part continuing technological advances. More cost sharing, at least that with a catastrophic cap on out-of-pocket expenses, has not been shown to make any difference in the expense per hospital admission. Only 2 percent of the growth in hospital costs under medicare is due to an increase in admissions. Per capita physician office visits by the elderly have actually declined slightly since 1974. For these reasons, increased cost sharing is unlikely to have much effect on medicare's most pressing problem—the steadily rising trend of hospital costs.

Added cost sharing does more than just reduce demand of course; it also shifts costs to those using services. To understand who experiences the impact of increased medicare cost sharing, it is necessary to look not at the averages but at subgroups of the elderly, because the elderly are not a homogeneous population. There are marked differences among the elderly in health status and in ability to pay for medical care. The bulk of medicare dollars go for care of enrollees who are severely ill; 12 percent of elderly enrollees accounted for 78 percent of the medicare dollars spent in 1981. Older, poorer, chronically ill, and terminally ill enrollees are the most likely to be high users of care.

Cost sharing related to utilization falls the hardest on the sickest and those with lower incomes, particularly those covered only by medicare. High users of medicare services are no more likely than aged enrollees in general to have other forms of insurance (private insurance or medicaid). Twenty percent have only medicare's protection. The poor and low-income elderly (incomes less than two times poverty) make up half of all enrollees, and 25 percent of them have medicare only. Only one out of four poor aged enrollees (incomes below poverty levels) is also covered by medicaid.

Without any increase in cost sharing the elderly already have significant out-of-pocket costs; they paid 29 percent of their medical bill ($1,187 per capita), or 13.6 percent of income for health care in 1981. Even excluding long-term care, noninstitutionalized aged enrollees paid about 20 percent of their medical bill out of pocket. The actual dollar amount of out-of-pocket expenses is about the same for all income groups, but its impact varies dramatically. The poor and near poor paid 14 percent of their income for out-of-pocket health care expenses in 1977, while those in the highest income group (four times poverty or more) spent on average only 1 percent of income for out-of-pocket health care expenses.

Medicare as currently designed hardly provides first dollar coverage. For enrollees who used any medicare services, cost-sharing liability for medicare-covered services in the form of deductibles, coinsurance, and excess charges from unassigned claims averaged $679 per capita in 1981 and $816 in 1982. For those without other forms of coverage, this is a substantial incentive against unnecessary use.

Indeed, the over 1 million poor and near-poor elderly with only medicare coverage already face considerable hardship and use substantially fewer medical services.

While many elderly with lower incomes struggle to pay increasingly higher private insurance premiums (an average of $250 to $550 in 1983), those most likely to have the most comprehensive private insurance are younger, healthier, and wealthier beneficiaries. They will be the least likely to feel the burden of increased cost sharing.

## 6. MEDICARE'S SHARE OF PERSONAL HEALTH CARE COSTS

Although medicare's share of the elderly's health bill has been steadily increasing since 1970, the program still pays less than one-half of the elderly's cost of care.

TOTAL PER CAPITA PERSONAL HEALTH CARE EXPENDITURES NOT PAID BY MEDICARE AS A PERCENT OF TOTAL INCOME FOR THE ELDERLY

| Year | Total per capital expenditures | Medicare per capita expenditures | Expenditures net of medicare | Personal income | Percent |
|---|---|---|---|---|---|
| 1965 | $472 | | $472 | $2,137 | 20.4 |
| 1970 | 854 | $351 | 503 | 2,991 | 16.8 |
| 1976 | 1,624 | 703 | 921 | 5,147 | 17.9 |
| 1977 | 1,821 | 805 | 1,016 | 5,592 | 18.2 |
| 1978 | 2,026 | 893 | 1,133 | 6,161 | 18.4 |
| 1981 [1] | 3,140 | 1,423 | 1,717 | 8,630 | 19.9 |

[1] Estimates supplied by the Health Care Financing Administration.

Source: Fisher, Charles R. Differences by Age Groups in Health Care Spending. Health Care Review, v. 1, No. 4, Spring 1980.

This doesn't mean that medicare pays the same for all services. Medicare pays a higher percentage of the bill for services it was designed to provide. For example, medicare pays a substantially higher portion of hospital and doctor bills than it does for nursing home services, or drugs and eyeglasses.

### (A) HOSPITAL SERVICES

Medicare paid, on average, 74 percent of an older person's $1,381 hospital bill in 1981. This percentage has remained essentially constant since 1976.

Hospital expenditures represent the single largest component of the medicare program, over 70 percent of the dollars medicare spends for health care. Medicare's share of hospital expenditures was about the same in 1981 (74 percent) as in 1978 (74.6 percent).[2] The structure of the hospital benefit, which imposes a deductible equal to the average hospital cost of 1 day of care ($356 in 1984) but no copayments until after 60 days of care, is largely responsible for the strength of medicare's performance. Since only 4 percent of medicare beneficiaries use more than 60 days, total out-of-pocket hospital expenditures are relatively small.

---

[2] Ginsburg, Paul and Marilyn Moon. An Introduction to the Medicare Financing Problem. Congressional Budget Office. U.S. Congress. House Committee on Ways and Means. Conference on the Future of Medicare. Conference Schedule and Preliminary Papers. Washington. U.S. Govt. Print. Off., 1983. Committee Print WMCP 98-20. Nov. 29, 1983. pp. 6-8.

### (B) PHYSICIAN SERVICES

Medicare's share of charges for physician services was 56 percent in 1978, and an estimated 55 percent in 1983. Medicare pays a considerably smaller portion of physician services than it does of hospital services. There are two reasons why medicare coverage of physician services has not been as effective as that of hospital services.

First, medicare's 20 percent coinsurance on physician services means that, under the best of circumstances, medicare would only pay 80 percent of charges (less the annual $75 deductible). Second, physicians are free to bill the patient at a rate higher than a "reasonable charge," leaving the patient to pay the 20 percent copayment plus the additional amount above the "reasonable charge." Where the deductible had been met, medicare's payment (after beneficiary coinsurance payments) would on average equal only 61 percent of the total physician's bill. This is because reasonable charges in fiscal year 1982 constituted only 76.2 percent of actual physician charges.

The assignment rate (the percent of claims where the physician will accept medicare payment in full and not bill the beneficiary for more than the 20 percent coinsurance), has remained just above 50 percent since 1974. Thus, for almost 50 percent of the claims, beneficiaries are responsible for the difference between reasonable charges and actual cost. This difference has risen, on average, from 13.6 percent of the total amount of a claim in fiscal year 1974 to 24.1 percent in fiscal year 1982. The difference between reasonable charges and billed charges is seldom covered under private supplemental insurance or medicaid.

Assignment rates fall further when medicare/medicaid claims for which assignment is considered mandatory are removed from the sample. A 1975 Urban Institute study in California showed total assignment rates of 60 percent for general practitioners, 56 percent for surgeons, and 40 percent for internists. When the joint medicare/medicaid claims were removed, the voluntary assignment rate was only 33.3 percent for general practitioners, 37 percent for general surgeons, and 22 percent for internists.

## 7. HEALTH COSTS NOT PAID BY MEDICARE [3]

There are five major sources of health care costs for the elderly not paid for by medicare:

*Uncovered services.*—Since medicare essentially covers only acute care, many services remain outside its scope of benefits. For example, preventive measures (with the exception of pneumococcal vaccine), outpatient drugs, eyeglasses, and basic dental services are not covered. In addition, the hospital and nursing home benefits are each limited to 150 days; and home health and nursing home benefits are limited to those who require skilled care.

*Cost sharing.*—Medicare cost sharing including a first day hospital deductible per admission ($356 in 1984), copayments on hospital and nursing home services, and a $75 per calendar year initial deductible and 20 percent coinsurance on physician and outpatient services. The hospital and nursing home deductible and copayment amounts are automatically increased each year.

---

[3] From the forthcoming committee print of the U.S. Senate Special Committee on Aging on medicare cost sharing, March 1984.

*Catastrophic costs.*—Beneficiaries requiring more than 60 days of care (about 4 percent of the medicare population) are liable for a daily coinsurance charge equal to one-fourth of the inpatient deductible for the 61st through 90th days. Patients requiring stays in excess of 90 days may draw on a 60-day lifetime reserve subject to a daily coinsurance charge equal to one-half of the deductible. No protection is available after 150 days. Thus while the program offers good protection for the majority of beneficiaries, it offers less adequate coverage for patients requiring stays over 60 days and no protection for the small number who exhaust all their hospital benefits. Further, there is no upper limit on required cost-sharing charges associated with part B services.

*Charges in excess of medicare payments for covered services.*—When physicians bill a medicare patient directly for services ("unassigned claims"), the beneficiary must then pay not only the 20 percent coinsurance but also any amount above what medicare considers "reasonable" for that claim (as determined by law and regulation). Almost 50 percent of all physician claims are unassigned.

*Premiums.*—Although not included in total personal health care expenditures, beneficiaries also pay a monthly premium for medicare coverage for physician services. The premium increases automatically each year and in 1984 is $14.60 per month.

## 8. OUT-OF-POCKET COSTS [4]

Despite the increase in medicare's share of the elderly's health care bill, the elderly pay a substantial portion of that bill out of pocket and spend an increasing amount of their incomes for health care.

In 1977, the Health Care Financing Administration estimated that direct out-of-pocket payments accounted for 29.1 percent of total payments, the highest source of payment after medicare. When the per capita costs of insurance premiums are added, the elderly's out-of-pocket health costs equaled 11.8 percent of their average annual income.

If the share of direct out-of-pocket costs remained the same in 1981, and there is little evidence to indicate that it did not, the elderly's out-of-pocket health costs would have equaled 13.6 percent of their income. As the increase in medical costs continue to outstrip the growth of income, out-of-pocket costs will continue to consume a larger share of the elderly's resources.

To understand the effects of cost sharing on beneficiaries—both in use of and access to services—it's necessary to look behind the averages to the differences in beneficiary use of services, income, and insurance coverage.

---

[4] Ibid.

In 1981, three-fourths (74 percent) of aged beneficiaries used less than 5 percent of all reimbursed services. Thirty-seven percent used no reimbursed services at all. On the other hand, 7 percent of the aged beneficiaries accounted for two-thirds of all reimbursements for the aged, while 1.4 percent of the elderly medicare population with the highest expenditures, $15,000 and over, used one out of four medicare dollars spent for the elderly.

According to CBO and the medicare history sample, aged enrollees incurring large costs are more likely to be older and have less income, and be chronically ill or terminally ill.

The terminally ill account for a disproportionate number of high cost beneficiaries. A recent study by the Health Care Financing Administration using 1976 data found that terminally ill enrollees in their last year of life comprised 5.2 percent of medicare enrollment and accounted for 28.2 percent of program expenditures. Reimbursements for the last 180 days of life comprised 21 percent of total medicare expenses, and reimbursements in just the last 30 days make up 8 percent of total medicare expenditures. From these and other data, it now appears that the higher per capital health care costs of the elderly are caused by the high costs of care for the terminally ill rather than by aging, per se.

## B. MEDICAID

The medicaid program provides matching funds to States to finance medical care for low-income persons who are in families with dependent children, or who are aged, blind, or disabled. Federal financial participation in the medicaid program is based on a matching rate according to a State's per capita income. Although the program is governed by a mixture of Federal and State eligibility requirements, the States are responsible for the administration of their respective medicaid programs. It is estimated that 3.5 million of the 22.6 million medicaid recipients are elderly.

Medicaid expenditures increased from $4.9 billion to an estimated $35.5 billion between 1970 and 1983, a 624 percent increase. Medicaid costs in fiscal year 1982 were $32.4 billion, in fiscal year 1982—$17.5 billion Federal, $14.9 billion State. Estimated medicaid costs in fiscal year 1983 are $35.5 billion—$19.3 billion Federal, $16.2 billion State.

Program expenditures are heavily weighted toward institutional services, especially long-term care. Federal and State medicaid spending for nursing home care, totaling $13 billion in 1982, constituted 43 percent of medical vendor payments, while inpatient hospital care represented 30 percent. The remaining 27 percent was accounted for by physician care, outpatient hospital services, drugs, and home care.[5]

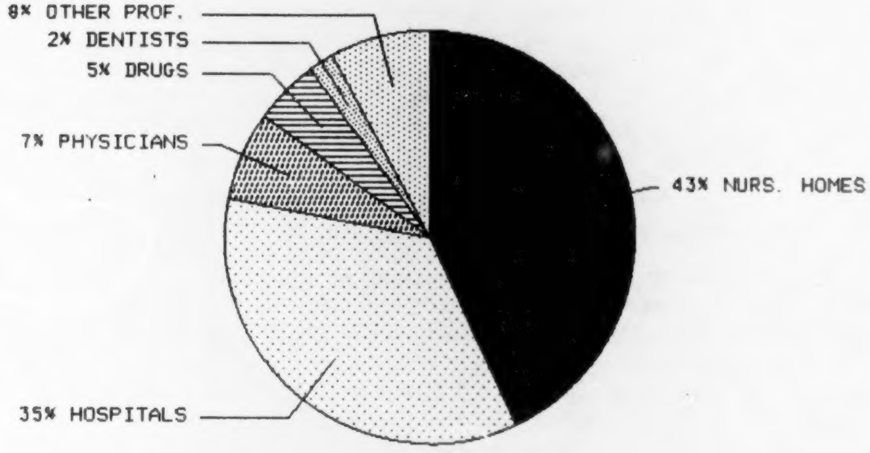
Chart 2 shows where the medicaid dollar was spent for personal health services in fiscal year 1982.

---

[5] Health Care Financing Administration. Unpublished tables.

CHART 2

WHERE THE MEDICAID DOLLAR GOES - 1983 ESTIMATES



Source: Health Care Financing Administration

During the past few years, both Federal and State governments have taken some action to limit rapidly growing medicaid costs. The 1981 Omnibus Reconciliation Act (OBRA) reduced Federal matching payments to States by 3 percent in fiscal year 1982, 4 percent in fiscal year 1983, and 4.5 percent in fiscal year 1984. Under certain circumstances a State may be able to partially or fully offset the amount of the reduction. The act also increased State flexibility to encourage cost-effective arrangements with service providers and expand home- and community-based long-term care services, if not more costly than institutional care. The Congressional Budget Office estimates that total Federal outlay savings resulting from these legislative changes are $3.9 billion over the fiscal year 1982 to fiscal year 1985 period.

### 1. STATE ACTIONS

Federal spending reductions, rapidly increasing medical costs, and State fiscal problems have combined to cause many States to take cost-savings action. Medicaid has become one of the largest programs that most States fund and the most rapidly increasing item in most State budgets.

The Federal cutbacks including in OBRA only exacerbated the fiscal pressures many States had been experiencing. The first response to the legislation was to make cutbacks in the scope of program coverage. Surveys conducted by the Intergovernmental Health Policy Project found that in 1981 more than 30 States took some action resulting in reductions or limitations on either benefits, eligibility, or provider reimbursement. The volume and severity of program limitations were not repeated in 1982. In fact a substantial number added new services, reinstated previously eliminated benefits, lifted restrictions on access, or even increased provider payments. During 1982 and again in 1983 States shifted their concentration to longer range structural reforms in the organization, financing, and delivery of medicaid services. States also responded to the flexibilities offered in OBRA including those which allow States to obtain waivers to restrict patient freedom of choice (section 2175 of OBRA) and waivers for home- and community-based services (section 2176 of OBRA).

## 2. Waivers

### (A) SECTION 2175, "FREEDOM OF CHOICE" WAIVER AUTHORITY

Under this authority, the Secretary of Health and Human Services may approve restrictions on the medicaid recipient's choice of providers or practitioners (other then emergency services) provided: (1) Such providers or practitioners accept and comply with the reimbursement, quality, and utilization standards under the State plan; (2) such restrictions are consistent with access, quality, and efficient and economic provision of services; and (3) the restriction does not discriminate among classes of providers on grounds unrelated to their effectiveness and efficiency in providing care.

Twenty-four States have applied for section 2175 waivers. Of the 70 applications made, 33 have been approved, 13 were disapproved, 13 requests were withdrawn, and 11 are awaiting decision; 23 of the 33 requests involve case management, and 7 restrict the providers from whom beneficiaries may obtain services.

### (B) SECTION 2176, HOME- AND COMMUNITY-BASED SERVICES WAIVER AUTHORITY

This authority permits automatically renewable waivers for States to provide coverage for a range of home and community-based services pursuant to an individual plan of care to persons who would otherwise require institutional services, provided that the States demonstrate that their waiver proposals do not increase medicaid costs.

Forty-six States have applied for section 2176 waivers. Of the 101 applications made, 58 were approved, 6 were disapproved, 6 were withdrawn, and 31 are pending. A more extensive discussion of these waiver proposals is included in the following chapter on long-term care.

## 3. Continuing Issues

Increasing medical costs and shrinking State budgets assure that medicaid cost containment will continue to dominate State health agendas in the near future. Many States have constitutional provisions which forbid unbalanced budgets; the result is a forced limit on medicaid spending. Medicaid eligibility requirements continue to vary from State to State, and States have marked differences in their ability to fund their share of the program.

Recent changes in legislation have stemmed the rapid increases in medicaid growth. Furthermore, the increased flexibilities granted to States under OBRA have permitted States to pursue a number of innovative approaches to restructuring their medicaid programs. However, concerns have been raised about the impact of restrictions and limits in eligibility, services, and reimbusement on the accessibility and quality of care for medicaid recipients. The American Hospital Association and others have pointed to the fact that the responsibility for providing care for the disadvantaged falls on a minority of hospitals "whose capacities are already severely strained in some communities."

Further concerns have been raised regarding the impact of freedom-of-choice waivers. Experience to date with such plans has highlighted some of the problems inherent in implementing major program changes. While these plans may result in cost-effective options for medicaid recipients which may actually provide more services and coordination of care, actions under these waivers could result in an ever wider distinction between systems of health care for the poor and nonpoor. In addition, the lack of freedom of choice increases the necessity for other measures to assure adequate quality of care.

Moratoria on nursing home bed construction and limits or reductions in nursing home reimbursements may also result in limited accessibility for medicaid patients, increased costs for private pay patients, and/or quality of care issues. These issues will be discussed in more detail in the chapter on long-term care.

## C. RESEARCH

The National Institutes of Health (NIH) is the principal medical research arm of the Federal Government. Its programs support basic and applied scientific inquiry on all phases of human diseases and disabilities, as well as investigations into fundamental biological processes and the biological effects of the environment. NIH is made up of a number of research institutes, many of which support extensive research on diseases of particular importance to the elderly. These include: cancer, diabetes, heart disease, stroke, arthritis, hypertension, cataracts, neurological disorders, and digestive diseases, among others.

The National Institute on Aging (NIA) is the newest institute of NIH. NIA supports a broad spectrum of research focused on easing or eliminating the physical, psychological, and social problems which affect the majority of older people. Areas of biomedical and clinical research include studies on the genetic determinants of aging; the etiology, diagnosis, and treatment of Alzheimer's disease; osteoporosis and osteoarthritis; problems of drug use by the elderly; the impact of nutrition on aging; depression; sleep disorders; and exercise physiology in the aged. The Institute also supports research in the behavioral sciences area such as cognitive and biopsychological aging; the influence of society and social institutions on people as they grow older; and the unique problems encountered by minorities as a subgroup of the aged.

The Institute continues to place major emphasis on disease prevention and health promotion. The concept of prevention is particularly relevant to the aged, who frequently suffer from chronic diseases or disabilities which require costly long-term institutional care. The Institute recently developed a special award, the Teaching Nursing Home Award, to help address this problem. Another thrust in the direction of prevention has been the establishment and implementation of the Institute's Laboratory of Neurosciences, which will focus much of its clinical efforts on the study of Alzheimer's disease and related dementias.

## D. VETERANS ADMINISTRATION

The Veterans Administration provides health care services in VA hospitals, domiciliaries, nursing homes, and outpatient clinics; on a contract basis in non-VA hospitals and community nursing homes; and on a grant basis in State veterans' home facilities. In general, VA medical care is available to all veterans for a service-connected disability. Other veterans are eligible for care for non-service-connected conditions if they are unable to defray the cost of care elsewhere or are age 65 or older, and VA resources are available. About 27 percent of hospital patients discharged from VA hospitals in fiscal year 1982 were 65 years and over. The average age of veterans treated in VA nursing homes in fiscal year 1982 was 70.1 years; 62.4 percent were age 65 or over. The average age of veterans in VA domiciliaries in fiscal year 1982 was 59.6 years; 29.9 percent were 65 years or over.

In fiscal year 1983, the VA spent an estimated $4.9 billion for medical care for veterans in VA and non-VA hospitals; nearly $50 million for nursing home care and approximately $100 million for domiciliary care in VA and non-VA facilities; and about $1.4 billion for outpatient care.

## E. THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

The Federal employees health benefits (FEHB) program provides health insurance coverage for approximately 10 million Federal Government employees and annuitants (i.e., retirees), and their dependents. Under the program, employees and annuitants are offered a choice of different health plans which have varying levels of benefits and premiums. The premium rates for the FEHB plans are paid through premium contributions by the Federal Government and by the enrolled employees and annuitants.

Currently, the program has no special provisions or plans for annuitants or medicare eligible persons.

# Chapter 12

# FEDERAL HEALTH LEGISLATION AND AGING COMMITTEE OVERSIGHT IN THE 98TH CONGRESS

## A. LEGISLATION ENACTED

### 1. MEDICARE

The change in medicare's method of reimbursing for hospital services was the major health legislative accomplishment of 1983. The change from cost-based reimbursement to price-based reimbursement of hospitals, to be phased in over 3 years, is designed to make hospitals cost conscious in their decisionmaking on patient treatment and hospital operation, and to reduce the rate of increase in medicare outlays for hospital services.

### (A) SOCIAL SECURITY AMENDMENTS OF 1983 (PUBLIC LAW 98-21)

Title VI of the Social Security Amendments of 1983 includes a new method of medicare reimbursement to hospitals. Effective for hospital cost-reporting periods beginning on or after October 1, 1983, medicare payment for hospital inpatient services are to be made according to a new prospective payment system, rather than on a "reasonable cost" basis. Medicare payments will be made at predetermined, specific rates which represent the average cost, nationwide, of treating a medicare patient according to the diagnosis. The classification system used to group hospital inpatients according to their diagnoses is known as diagnosis related groups (DRG's). If a hospital can treat a patient for less than the payment amount, it can keep the savings. If the treatment costs more, the hospital must absorb the loss. A hospital is prohibited from charging medicare beneficiaries any amounts (except for deductibles, coinsurance amounts, and services not covered by medicare) which represent any difference between the hospital's cost of providing covered care and the medicare DRG payment amount. The following describes the new system in more detail.

### *(1) Prospective Payment System*

Unless excluded from the prospective payment system, all medicare participating hospitals will be paid a specific amount for inpatient services provided to medicare beneficiaries, based on the patient's classification into 1 of 468 DRG's. Separate DRG rates will apply to hospitals located in urban and rural areas of the country (urban rates are higher than rural rates). The DRG rates will be adjusted for area differences in hospital wage levels compared to the national average hospital wage level.

### (2) Effective Date/Transition Period

Application of the DRG payment rates (urban and rural) will be phased in over a 3-year transition period, starting with each hospital's first cost reporting period which begins on or after October 1, 1983. During the transition period, a hospital's payment rate will be a combination of the DRG payment rates and a hospital's historical costs; in addition, during the transition, the DRG portion of the rate will be based on a combination of national rates and regional rates for each of the nine census regions of the country. Thus, during the first year of the program, 25 percent of the prospective payment will be based on regional DRG rates and 75 percent will be based on each hospital's cost base. In year 2, 50 percent of the payment will be based on a combination of national and regional DRG rates (25 percent national, 75 percent regional) and 50 percent will be based on each hospital's cost base. In year 3, 75 percent of the payment will be based on a combination of national and regional DRG rates (50 percent national, 50 percent regional) and 25 percent will be based on each hospital's cost base. In year 4, 100 percent of the payment will be determined under the national DRG payment methodology.

### (3) DRG Payment Levels and Updating

The payment rates for each DRG are derived from an average of all hospitals' historical (1981) medicare cost data. The rates are updated through fiscal year 1983 by the estimated actual rate of increase in hospital costs nationally. The rates will be further updated for fiscal year 1984 and fiscal year 1985 by the estimated annual increases in a market basket index representing the cost of goods and services purchased by hospitals, plus 1 percentage point. For each fiscal year beginning with fiscal year 1986, the Secretary is required to determine an appropriate increase to the DRG payments, taking into consideration the recommendations of a newly established Prospective Payment Assessment Commission. For fiscal year 1984 and fiscal year 1985, the DRG rates will be adjusted so that the total payments under the prospective system equal the payments which would have been made under the reasonable cost-reimbursement provisions of prior law (this requirement is known as "budget neutrality"). The Secretary is also required to adjust the DRG classification and weighting factors in fiscal year 1986 and at least every 4 years thereafter to reflect changes in treatment patterns, technology, and other factors which may change the relative use of hospital resources.

There were discussions in 1983, which could continue in 1984, concerning whether, in view of rising budget deficits and expenditures for hospital care under the medicare program, the prospective payment rates should be limited in 1984 or future years. Such limits could include freezing the rates at a previous year's level, limiting any increases in the rates to a specific percentage, or limiting the formula by which the rates are to be updated for fiscal year 1984 and fiscal year 1985 (i.e., market basket plus 1 percentge point). Close attention will be paid in 1984 to the activities of the Prospective Payment Assessment Commission, whose legislatively mandated responsibilities include making recommendations for updating the prospective payment rates for fiscal years beginning with 1986, and adjusting the DRG classifications and weighting factors to reflect changes in treatment patterns, technology, and other factors which may change the relative use of hospital resources.

### *(4) Additional Payment Amount*

In addition to the prospective payment rates per discharge, medicare payments will be made for the following items or services:

#### *(a) Outliers*

Additional amounts will be paid to hospitals for atypical cases (known as "outliers") which have either extremely long lengths of stay or extraordinarily high costs compared to most discharges classified in the same DRG.

#### *(b) Payments on a reasonable cost basis*

Costs for certain items are excluded from the prospective payment system and thus are not included in the prospective payment rates. Medicare will pay for its share of such costs separately from the DRG payment system, according to the former reasonable cost-based system. These costs include capital-related costs (depreciation, leases and rentals, interest, and a return of equity for proprietary hospitals), which are excluded from the prospective payment system until October 1, 1986. The Secretary is required to report to Congress within 18 months of enactment on methods and proposals by which capital costs can be included in the prospective payment rates. The law also prohibits medicare payment for capital costs after September 30, 1986, unless a State has a capital expenditure review agreement with the Secretary (under section 1122 of the Social Security Act) and the State has recommended approval of the specific capital expenditure. In addition, the direct costs (including overhead costs) of approved medical education programs are excluded from the prospective payment system and will continue to be reimbursed on a reasonable cost basis. Additional payments will be made to hospitals under the prospective system for the indirect costs of approved medical education programs.

### *(5) Special Treatment of Certain Facilities*

The law provides for certain exceptions and adjustments to the prospective payment rates for certain facilities such as sole community hospitals, cancer hospitals, regional and national referral centers, and public or other hospitals with many low-income patients or medicare beneficiaries.

### *(6) Hospitals Excluded From the Prospective Payment System*

The following hospitals are by law excluded from the prospective payment system and will be paid on the basis of reasonable costs: Psychiatric hospitals, rehabilitation hospitals, psychiatric or rehabilitation units which are distinct parts of a hospital, children's hospitals (with patients averaging under 18 years of age), long-term hospitals (with an average inpatient length of stay greater than 25 days), and hospitals outside the 50 States and the District of Columbia. Hospitals reimbursed under approved State cost-control systems in accordance with medicare demonstration projects are also excluded from the prospective rates.

### *(7) Review Activities*

The law requires that before October 1, 1984, hospitals receiving medicare payments must enter into agreements with organizations known as utilization and quality control peer review organizations (PRO's), if there is a PRO in the area that has contracted with the Secretary. PRO's are responsible for reviewing the necessity and reasonableness of care, the quality of care, and the appropriateness of the setting in which services are provided to medicare beneficiaries. As of October 1, 1984, hospitals are required to contract with PRO's as a condition of receiving payments under the medicare program.

### *(8) Special Costs and Facilities*

Provisions in the prospective payment legislation (Public Law 98-21) and in the implementation regulations (September 1, 1983) covering payment for certain costs may be reexamined in 1984. Such reexamination could be given to the costs of atypical hospital cases (known as "outliers") and to certain facilities, such as sole community providers, which are hospitals that by reason of factors such as isolated location, weather conditions, travel conditions, or absence of other hospitals are the sole source of inpatient services reasonably available in a geographic area; cancer hospitals; regional and national referral centers (including those with 500 or more beds located in rural areas); and public or other hospitals with many low-income patients or medicare beneficiaries.

### *(9) Assessing the Impact*

Since the start of the prospective payment system on October 1, 1983, questions have been raised concerning the impact of the system, including its effect on hospitals, the elderly, the practice of medicine, and the quality of care provided; on other insurers of medical care; and on outlays for the medicare program itself. Since the system has been so recently implemented and is still in transition with many of its aspects yet to be decided, it has been difficult to arrive at any definitive evaluations of how the system is working. However, data and information gathered during 1984 by hospitals, the Health Care Financing Administration (which administers the medicare program), and the professional review organizations will be useful in evaluating the impact of the system as it is implemented.

## (B) PROSPECTIVE PAYMENT TO SKILLED NURSING FACILITIES

The Tax Equity and Fiscal Responsibility Act of 1982, Public Law 97-248, requires the Secretary of Health and Human Services to develop in consultation with the Senate Committee on Finance and the House Committee on Ways and Means, medicare prospective reimbursement proposals for skilled nursing facilities (SNF's). A report from the Secretary was legislatively required to be transmitted to Congress by the end of December 1983; as of February 1, 1984, the Congress had not received this report.

### (C) MEDICARE PART B PREMIUM

The Secretary of HHS is required to calculate annually the increase in the premium under part B medicare. The annual premium rates (which until 1982 became effective every July) were the lower of: (1) An amount sufficient to cover 50 percent of the costs of the program for the aged, or (2) the current premium amount increased by the percentage by which cash benefits are increased under the cost-of-living (COLA) provisions of the social security programs. Premium income, which originally financed half of the costs of part B, declined—as the result of this formula—to less than 25 percent of total program income.

TEFRA temporarily suspended the COLA limitation specified above for two 1-year periods, beginning on July 1, 1983. During these periods, enrollee premiums would be allowed to increase to amounts necessary to produce premium income equal to 25 percent of program costs for elderly enrollees. The limitation would again apply with respect to periods beginning July 1, 1985, and thereafter.

Public Law 98-21 postponed the scheduled July 1, 1983, increase to January 1, 1984, to coincide with the delay in the cost-of-living increase in social security cash benefit payments. Future increases will occur in January of each year based on calculations made the previous September. Public Law 98-21 further provided that the suspension of the COLA limitations as authorized by TEFRA are to apply for the 2-year period beginning January 1, 1984.

### (D) PHYSICIAN REIMBURSEMENT REFORM

During 1984, the Congress is expected to again consider modifications or alterations in the current physician reimbursement requirements. Payment for physician services under medicare is made on the basis of "reasonable charges." The reasonable charge for a service (in the absence of unusual circumstances) cannot exceed the lowest of the physicians's actual charge, his customary charge for the service, or the prevailing charge for the service in the community.

Customary and prevailing charge screens are updated every July 1; year-to-year increases in the prevailing charge levels are subject to an economic index limitation. The economic index amount applicable for the 1 year period beginning July 1, 1983, is 5.8 percent. Medicare pays physicians 80 percent of the reasonable charge amount after the beneficiary has met the $75 deductible. The beneficiary is liable for 20 percent coinsurance charges. Payments are made either to the doctor or to the beneficiary, depending upon whether the physician has accepted assignment for the claim.

In the case of nonassigned claims, payment is made directly to the beneficiary on the basis of an itemized bill, paid or unpaid. The beneficiary is responsible for paying the physician's bill. In addition to the deductible and coinsurance amounts, he is liable for any difference between the physician's actual charge and medicare's reasonable charge. Alternatively the beneficiary may assign (i.e., transfer) his rights to payment to the physician, provided the physician is willing to accept medicare's reasonable charge determination as payment in full for a covered service. If the physician accepts assignment, the physician bills the program directly and is paid an amount equal to medicare's allowed charge less any deductible and coinsurance, and may not charge the beneficiary (nor can he collect from another party such as a private insurer) more than the applicable deductible and coinsurance amounts. When a physician accepts assignment, the beneficiary is protected against having to pay any difference between medicare's determined reasonable charge and the physician's actual charge.

Roughly 53 percent of claims are paid on an assignment basis, although the percentage of assigned claims is a good deal lower when claims for the dually eligible—medicare and medicaid—are excluded from the calculation. (Physicians are required to take assignment for services to medicaid patients.)

Recent discussions have focused on the impact of nonassigned claims on beneficiaries, possible modifications in the calculation of physician payment rates, and the rapid rise in program outlays (physician payments account for over 70 percent of SMI expenditures). In 1983, the Congress considered several modifications to the current system. Public Law 98-21, the Social Security Amendments of 1983, provided for the establishment of a prospective payment system for hospitals, with cases classified according to diagnosis related groups (DRG's). The new system does not apply to physicians services which are currently reimbursed under the SMI program.

Public Law 98-21 did, however, require the Secretary to begin in fiscal year 1984 the collection of data necessary to compute the DRG's on the amount of physician charges for services furnished to hospital inpatients classified according to DRG. Furthermore, in 1985, the Secretary is required to report recommendations to the Congress concerning the advisability and feasibility of making lump sum payments for physician services provided to hospital inpatients, according to the patients' DRG classifications.

During 1983, Congress also considered proposals to stem part B outlays by rolling back the prevailing charge screen increases which went into effect in July 1983, to the level which was in effect in June of that year. Concern was expressed that if this change were approved, more physicians would refuse assignment and, as a consequence, pass along to the beneficiary the charges not met by the program.

The Senate reconciliation bill (S. 2062), pending action at the close of the first session, would have required the publication of lists containing the assignment ratios for each physician. The reconciliation measure approved by the House Energy and Commerce Committee would require the Secretary to compile and publish a list of all physicians who agree to accept assignment for all their patients for the next year. The tax bill reported by the House Ways and Means Committee (H.R. 4170) included a provision (which was not approved by the full committee) which would limit the prevailing charge screen rollback to services provided to hospital inpatients (about 60 percent of the total) and mandate assignment for such services.

These various approaches are expected to be considered when Congress reconvenes in 1984. It is possible that the Congress might also consider other proposals dealing with physician assignment. These include proposals which would mandate assignment for all services or give physicians a choice of having either all of their claims or none of their claims paid on an assignment basis.

### 2. LABOR AND HEALTH AND HUMAN RESOURCES APPROPRIATIONS BILL OF 1983 (PUBLIC LAW 98-139)

Of the Nation's basic research, 80 to 90 percent is financed by the Federal Government. Most of this research is carried out by the National Institutes of Health (NIH).

The biomedical research activities of NIH, including those of the National Institute on Aging (NIA), are supported through congressional appropriations to the Department of Health and Human Services. Expanding Federal involvement in biomedical research has resulted in a 12.5 percent annual increase in expenditures between 1970 and 1981, or 4.3 percent after adjusting for inflation.

There was no increase in Federal expenditures for health research in fiscal year 1982, with programs continuing at fiscal year 1981 levels of $3.8 billion. The fiscal year 1984 appropriation (Public Law 98-139, H.R. 3913) gave NIH over $4.3 billion, an increase of 7 percent over the 1983 appropriation of $4 billion. NIH supports research on numerous diseases of importance to the elderly. The National Institute on Aging will spend nearly $115 million to support its specific aging-related programs in fiscal year 1984. In granting the appropriation for NIA, the conferees stated their agreement that "the amount provided includes $3.5 million for the establishment of not more than five specialized research centers for research on Alzheimer's disease and related disorders." (H. Rept. 98-422 on H.R. 3913).

Several provisions of interest to the elderly are found in proposed legislation reauthorizing selected NIH programs. Two bills pending in the 98th Congress, H.R. 2350 and S. 773, extend through fiscal year 1986 the authorization for the National Cancer Institute, the National Heart, Lung, and Blood Institute, several arthritis, diabetes, and digestive diseases programs, and other NIH activities. In addition, the bills create a new institute within NIH which would focus on research into arthritis and musculoskeletal diseases. Both bills require an additional focus on Alzheimer's disease, and the House bill requires the conduct of a study on the adequacy and availability of personnel to meet the health needs of the elderly for the next four decades. The House has passed H.R. 2350, and the Senate Committee on Labor and Human Resources has reported S. 773.

### 3. THE 1984 HOUSING AND URBAN DEVELOPMENT—INDEPENDENT AGENCIES APPROPRIATIONS BILL, PUBLIC LAW 98-45 VETERANS HEALTH

In fiscal year 1984, the VA is expected to accommodate over 18.5 million outpatient medical and dental visits and to treat nearly 1.4 million patients in VA and community facilities. Public Law 98-45, the HUD-Independent Agencies Appropriations legislation for fiscal year 1984, appropriated $8 billion for VA medical care for fiscal year 1984.

### 4. THE VETERANS' HEALTH CARE AMENDMENTS OF 1983 (PUBLIC LAW 98-160)

This legislation authorized the VA until September 30, 1988, to provide adult day health-care programs for veterans eligible for nursing home care.

The many veterans of World War II and the Korean War are now approaching or have already reached age 65, at which age they receive a higher priority for VA care. Because of their large number, these veterans may put increasing pressure on the VA health care system: The number of elderly veterans will more than double between 1980 and 1990—from about 3 million to more than 7.5 million. Horgan, Taylor, and Wilensky predict that the number of elderly veterans using the VA system for ambulatory physician visits, short-term hospital stays, and prescribed medicines will double between 1977 and 1987; in absolute numbers, this would be an increase of 200,000 elderly users.[1]

The impact of the increase in the elderly veteran population on the VA system for outpatient care, acute care, and medicine is probably less than suggested by the projected increase in the elderly veteran user population. In the first place, elderly users will continue to be a minority of total users; in the second place, projections show a decline in this decade in the number of nonaged users. The situation with regard to long-term care may be different, with a likely larger increase in demand for this service. This is because use of the VA health care services is highest among veterans without insurance coverage; and private insurance and medicare insurance for nursing home care is minimal.

### 5. THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

Several bills introduced in the first session of the 98th Congress have provisions which apply specifically to the elderly or medicare-eligible population, as described below:

—H.R. 656 (Oakar), in addition to other items, provides for an additional premium payment by the Federal Government, equal to 5 percent of the average premium cost of the six largest plans in the FEHB program, for each enrolled employee or annuitant who is age 65 or older and is not entitled to part A (hospital insurance) of medicare. In addition, the bill prohibits FEHB plans from excluding individuals because they are annuitants.

—H.R. 3798 (Dannemeyer, by request), among other items, provides that if a retired employee enrolls in a self-only FEHB plan, the Federal Government's contribution toward the premium would be equal to the premium charge for supplementary medical insurance (part B) benefits under the medicare program.

---

[1] C. Horgan, A. Taylor, and G. Wilensky, "Aging Veterans: Will They Overwhelm the VA Medical Care System," Health Affairs, fall 1983, pp. 77-86.

—S. 1685 (Durenberger), among other items, requires the Office of Personnel Management (OPM) to adjust the Government's contribution to a FEHB plan for annuitants to compensate plans for the higher medical costs of annuitants as compared to employees and, beginning in 1985, to adjust the Government's contribution for the age, sex, and place of residence of all enrolled employees and annuitants. In addition, beginning in 1985, S. 1685 requires medicare-eligible employees and annuitants to elect either (1) to enroll in a newly established medicare supplementary plan (if the employee is 70 or older), (2) to have the Government contribute toward enrollment in an eligible competitive medical plan (such as a health maintenance organization), or (3) to have the Government contribute toward enrollment of a medicare-eligible's spouse in a FEHB plan. S. 1685 provides that the Government contribution toward any of the three options be $20, adjusted by the percentage change in the medical care component of the Consumer Price Index.

—S. 2027 (Stevens), among other items, authorizes the establishment of medicare supplemental plans under the FEHB program, with authority for a member of a family of an employee or annuitant enrolled in a medicare supplemental plan to enroll in any FEHB plan. S. 2027 provides for an additional Federal contribution (84 percent rather than 70 percent of the weighted average of all FEHB premiums) for an annuitant who is not eligible for hospital benefits under medicare.

## B. LEGISLATION PROPOSED

### 1. Administration Budget Proposals for Medicare and Medicaid

The President's fiscal year 1984 budget contained various legislative proposals designed to achieve reductions in Federal fiscal year 1984 outlays of $1.9 billion for medicare and $382 million for medicaid. Implementing changes were incorporated in three measures introduced by Senator Dole by request. They are:

—S. 641, the Medicare Voucher Act of 1983. This bill would establish a voluntary medicare voucher program under which beneficiaries could select to enroll in a comprehensive capitated health benefits program, e.g., those provided by certain health maintenance organizations, rather than participate in the present medicare program which reimburses providers on a fee-for-service basis.

—S. 642, the Medicare Catastrophic Cost Protection Act. This measure would restructure the current inpatient hospital and skilled nursing facility cost-sharing requirements in order, it is argued, to encourage greater cost consciousness among medicare patients and reduce unnecessary hospital days. The bill would: (a) Impose new daily copayment requirements on the second to 60th day of hospital care (which currently are not subject to cost-sharing requirements); (b) delete existing cost sharing applicable to hospital stays in excess of 60 days; (c) limit the number of times a beneficiary must pay the inpatient hospital deductible to two per year; and (d) reduce the current copayment amounts applicable to skilled nursing facility care.

- —S. 643, the Health Care Financing Amendments of 1983. This legislation contained a number of medicare and medicaid provisions. Medicare provisions include those which would temporarily freeze physician payments, provide for the annual indexing of the part B deductible, and modify the rate of increase in the part B premium. Medicaid provisions included those which would mandate the imposition of copayments for specified services and extend indefinitely the existing provisions (added by Public Law 97-35) which provide for a reduction (with certain offsets) in Federal matching funds payable over the fiscal year 1982 to fiscal year 1984 period.

### 2. RECONCILIATION

A modified version of the administration's proposal for prospective payments to hospitals was approved by the Congress as part of Public Law 98-21. The remaining administration proposals were considered in the context of the budget reconciliation process.

On June 23, 1983, the House and Senate approved the conference report on the first concurrent resolution on the budget. This resolution assumed medicare savings of $400 million in fiscal year 1984, $500 million in fiscal year 1985, and $800 million in fiscal year 1986. However, these savings were not to be achieved through reductions in benefits or increases in beneficiary cost-sharing charges. The resolution assumed no medicaid savings over the fiscal year 1984 to fiscal year 1986 period; it did, however, assume additional amounts ($200 million in fiscal year 1984, $250 million in fiscal year 1985, and $500 million in fiscal year 1986) for a child health assurance program. At the close of the first session of the 98th Congress, reconciliation measures which had been reported by the appropriate committee were pending in both the Senate and the House.

#### (A) SENATE ACTION

On November 4, 1983, the Senate Committee on the Budget reported the Omnibus Reconciliation Act of 1983 (S. 2062). This measure incorporated the budget reconciliation proposals which had been approved by the Finance Committee on October 31, 1983. S. 2062 includes a number of medicare and medicaid cost-savings provisions as well as other technical changes. These include the following:

- —Effective December 1, 1983 to June 30, 1984, the prevailing fees for physicians services would be rolled back to the level in effect on June 30, 1983.
- —The Secretary would be required to publish lists containing the assignment ratios for physicians providing medicare services.
- —The present temporary provision relating to calculation of the part B premium would be extended for 1-year, beginning January 1986. For this period, premiums would be set at a rate equal to 25 percent of the estimated per capita program costs for the aged.
- —The part B annual deductible (currently set at $75) would be increased for 3 years beginning in 1984 by the percentage by which the medicare economic index increases each year.

- A fee schedule would be established for non-hospital-based clinical laboratory services. Clinical laboratories and physicians would not be required to accept assignment for such services; however, payment would equal 100 percent of the fee schedule amount where such election were made.
- The Secretary would be required to make appropriate adjustments in the area wage index utilized for the prospective payment system.
- The current physician recertification schedule for skilled nursing and intermediate care facility services under medicaid would be revised.

The Senate Aging Committee held hearings in 1982 which reviewed the findings of a yearlong investigation of the purchase and use of cardiac pacemakers under medicare. The committee concluded that a sizable portion of the costs assumed by medicare could be questioned based on findings of unreasonable costs, overutilization, failure to assure that manufacturers fulfill their warranty obligations, excessive frequency in monitoring activities, and fraudulent and abusive activities. In partial response to these findings, S. 2062, as reported, requires the Secretary to issue revisions in coverage guidelines on the frequency of transtelephonic monitoring procedures which are reasonable and necessary. The Secretary would also be required to review the current rate of reimbursement associated with implantation of pacemakers and pacemaker leads. In addition, the provision provides for the establishment of a manufacturer-based registry of all cardiac pacemaker devices and leads for which medicare payments may be made. Elements of S. 2062 and its House companion were included in both House and Senate versions of the budget reconciliation bills.

### (B) HOUSE ACTION

On October 31, 1983, the House Ways and Means Committee reported H.R. 4170, the Tax Reform Act of 1983. This measure included a number of medicare cost reduction proposals as well as other medicare changes. It provides for the use of fee schedules for clinical laboratory services, the continuation of existing temporary provisions regarding calculation of part B premiums, and for adjustments under certain circumstances in the hospital wage index used under the prospective payment system. The bill also limits reimbursement for transtelephonic monitoring procedures (for certain single chamber cardiac pacemakers) to the frequency established in new guidelines to be issued by the Secretary, or, in the absence of such guidelines, the frequency established in the law. The Secretary is also required to study payments for pacemaker implantations. Furthermore, the Secretary through the FDA is required to establish a registry of devices and leads.

The reported bill also included a provision (which was not approved by the full committee) to roll back prevailing charge levels for physician services to hospital inpatients to the levels in effect in June 1983. It would also require physicians to accept assignment for such services. It would modify the medicare provider agreement required for all hospitals receiving program payment. The new agreement would obligate hospitals to obtain signed agreements from each physician on its medical staff (courtesy or otherwise) who provides inpatient services in the hospital, stating that the physician agrees to accept assignment for any medicare beneficiary he treats as an inpatient. The hospital would not be responsible for enforcing the assignment agreement.

On October 26, 1983, the House Energy and Commerce Committee approved the Medicare and Medicaid Budget Reconciliation Amendments of 1983 (H.R. 4136). This legislation includes provisions similar to those included in the Ways and Means bill with respect to reimbursement for pacemaker services and clinical laboratory services. With respect to physicians, the legislation would require a study of physicians payments and the compilation and publication by the Secretary of a list of physicians who agree to accept assignment for all of their patients in the coming year. The medicaid changes in H.R. 4136 included a provision, similar to that in the Senate measure relating to the frequency of physician recertification for SNF and ICF services.

## C. COMMITTEE OVERSIGHT HEARINGS

### 1. WASHINGTON, D.C., HEARINGS

#### (A) QUALITY ASSURANCE UNDER PROSPECTIVE PAYMENT PROGRAM

As 1983 began, the Congress was considering legislation to alter the method by which medicare pays for hospital care—to change from paying hospital costs to paying a fixed price per diagnosis, with the price to be set in advance of treatment. Because there was concern among the members of the Senate Committee on Aging about the impacts of this reimbursement method on beneficiaries, on February 4, 1983, the committee convened an investigative and oversight hearing to consider evidence on the effects of prospective reimbursement on quality of care.

The committee heard testimony on case studies in two existing health prospective payment systems—medicaid prospective payment programs for nursing home care, and the New Jersey program of prospective payment for acute hospital care. Approximately three-fifths of all State medicaid programs reimburse nursing homes on a prospective basis; this experience is therefore useful in attempting to assess the impact that prospective payment systems can have on the quality of care in health facilities.

#### *(1) Autumn Hills Nursing Home Chain: A Case Study of the Failure To Assure Quality of Care in a Prospective Payment System*

It was against this backdrop that the committee heard testimony about the unusual case of Autumn Hills Convalescent Centers, Inc., a chain of 17 nursing homes in Texas, which is one of the States that pays a prospectively set rate for nursing home care. As of December 1980, Autumn Hills homes had 1,910 beds licensed by the Texas Department of Health, had an occupancy rate of 90 percent, and had all but two of its beds contracted to medicaid. The company's president owned 79 percent of Autumn Hills' outstanding stock and one other person owned the remainder of the stock.

One of the chain's nursing homes had its medicaid payments withheld on four separate occasions during 1978 and 1979 for serious deficiencies in compliance with medicaid health and safety standards and for failure to correct deficiencies in dietary, pharmacy, and nursing services. The health department recommended decertification of the home in August 1979, but reconsidered after the home made a number of improvements.

Audits of the Autumn Hills chain by the U.S. General Accounting Office determined that cost reports submitted for 1978 and 1980 included significant amounts of unallowable and questionable costs. For 1980, GAO questioned about 18 percent of the $1.5 million central office costs, including such costs as interest on personal loans, personal travel, purchases of bank stock, and private automobile expenses. Because Texas pays on a prospective basis and not on the basis of individual facility costs reports, none of these unallowable or questionable costs have been recovered by the State.

Documents acquired by the committee indicated that not only was Autumn Hills profitable to its owner, but that as a whole, nursing homes in Texas in 1979 were immensely profitable. The average return on equity for Texas nursing homes was 33.8 percent, a rate higher than oil, banks, and fast food franchises.

Witnesses before the committee in this early part of its hearing seemed to suggest that lessons to be drawn from State prospective systems for nursing home reimbursement include:

—Audits are needed to verify rates and can produce cost-beneficial results.

—Prospective reimbursement can restrain health costs but, because direct patient care represents the highest area of cost, it creates a need to review and monitor the quality of care being provided.

—If prospective rates are not sensitive to needs of individual patients, this reimbursement method could restrict access for those patients needing more expensive (intensive) care.

—A system of financial fines for providing substandard care—as determined by periodic inspection or other utilization control mechanisms—is a viable component of a prospective system.

—Prospective systems inherently carry with them incentives to cut care.

—Current licensure and inspection mechanisms do not measure quality of care, they are not patient specific.

—Upgraded utilization review activities and/or further enhancement of PSRO-like activities is needed in a prospective environment.

—Prospective reimbursement is like a contract in which the payer agrees to pay a certain rate for a given set of services. The contract, in order to work properly, must be specific as to terms, particularly as to the performance requirements of the service provider. Full payment is predicated on the full delivery of needed service.

—Effective quality of care measures track patient outcomes and the delivery of specific services. Monitoring the capacity of an institution to deliver service is insufficient.

### *(2) The New Jersey PSRO Experience With Prospective Reimbursement*

Administration witnesses testified that much of the department's proposal was modeled after the DRG-based prospective reimbursement system developed in New Jersey. The administration's proposal differed in that New Jersey's system includes all payers and reimbursement for capital costs and it also had a PSRO-based quality of care component. Since at this hearing the committee was concerned with quality of care issues, it focused some of its attention on the role of PSRO-type quality and utilization reviews.

Two witnesses, both of whom had extensive PSRO experience in New Jersey, presented testimony. The witnesses concurred that while prospective reimbursement may help reduce long-run health costs, the tough task is to reduce services only to the minimum, and not below that which is medically necessary. They noted problematic aspects of the New Jersey program. These include the incentives in the program to increase unnecessary admissions, reduce services below acceptable levels, and manipulate DRG coding.

The committee heard conflicting testimony on whether utilization control could be done effectively by intermediaries' analysis of their computer billings or required physician involvement in the review process.

Just prior to the hearing and after nearly 3 months' effort, the committee was able to obtain a copy of a closely guarded HHS internal memo—the Toby memo—which documented significant problems in the New Jersey DRG program upon which the administration's own proposal was based. (At the time, William Toby was the HCFA Regional Administrator for region II, which includes New Jersey.) The Toby memo, in part, noted the following:

—That DRG gaming of diagnosis classifications could be as much as 14 percent more costly to the program than cost-based systems.

—That an additional 9 percent in increased costs could be incurred by the program when hospitals misdiagnose cases.

—That extensive guidance and careful monitoring must be performed to prevent excessive use of costly "outlier" classifications.

—That more and new types of utilization review and quality assurance are needed.

—That steps need to be taken to guard against windfall profits.

—That there are incentives in DRG's to game by shifting ancillary services delivery out of the hospital.

—That to avoid unwanted cost shifts, a prospective DRG system must include all payers within a geographic area.

—That costs under the old cost system would have risen only 9.7 percent when in fact for DRG's they increased by 16.3 percent.

—That the DRG program paid out approximately $30.9 million in excess DRG payments, that extensive and continued auditing is necessary to track changes in the system.

HCFA officials responded to what was contained in the Toby memo by suggesting that much of it was irrelevant to the HHS Department's proposal. They adopted the position that the effects noted were overstated and, where warranted, had been accommodated in the HHS Department's proposal.

Committee members noted that if the Toby memo is correct and large windfalls can occur, and if the Autumn Hills example in which decreased care led to increased profits not recoverable by the program, were at all representative, then the fiscal integrity of a national prospective payment system was a great risk. To the extent that the product which a prospective payment system is buying is not clearly specified, the opportunity for abuse abounds. As some witnesses before the committee discussed, the health system may have arrived at a time when specific performance criteria need to be developed for the government's purchase of health care.

### *(3) Congress Acts To Adopt DRG's*

On April 20, 1983, subsequent to the committee's hearing, Congress enacted Public Law 98-21, which mandated adoption of a DRG-based prospective payment system for medicare hosptial services. The law, as adopted by Congress, seriously amended the administration's original proposal and addressed many of the issues raised at the Aging Committee's hearing. For example, Congress required that outliers be severely limited; that audited cost reports be maintained; and restricts overall growth in medicare outlays for hospital care.

In later action Congress enacted the professional review organizations (PRO's) legislation which provided national funding for utilization review and quality of care surveillance. In short, the committee's hearing did much to expose important issues surrounding the assurance of quality of care in a prospective payment system.

## (B) "THE FUTURE OF MEDICARE"

On April 13, 1983, the Senate Special Committee on Aging convened the first in its series of hearings on the future of medicare. Dr. Alice Rivlin, Director of the Congressional Budget Office (CBO), released an information paper prepared for use by the committee. The CBO paper, "Prospects for Medicare's Hospital Insurance Trust Fund," presents projections of outlays and income for the HI trust fund for the next decade and describes the changes that would be needed to prevent depletion of the fund.

The CBO paper indicated that the HI trust fund could be depleted as soon as 1987 or 1988. To eliminate the deficit projected to increase annually after 1988 or 1990, the paper noted, would require a significant increase of income taxes or substantially tighter control on hospital costs. The cumulative projected deficit is so large, according to the CBO paper:

> * * * $300 to $400 billion by 1997—(that) maintaining solvency through 1995 will require substantial policy changes. Avoiding deficits through policies to reduce outlays would require actions significantly more stringent than any being discussed today.

In the opening testimony before the committee, Dr. Rivlin explained that the problem of the HI trust stems from the fact that outlays are determined by hospital costs that are growing more rapidly than the earning to which the HI tax is applied.

Dr. Rivlin told committee members:

> The deficit of the HI trust is of such a magnitude that resolving it through any single change in medicare is unlikely to be politically acceptable. Some combination of available options will likely be required.

Dr. Rivlin noted that successive tightening of reimbursements could cut Federal outlays substantially, but cautioned that if restraints applied only to medicare reimbursement rates and not to the rates paid by private insurance companies, this would create a substantial risk of discrimination by hospitals against medicare beneficiaries that would reduce their access to quality care.

Also testifying before the committee was Dr. Carolyne Davis, Administrator of the Health Care Financing Administration within the Department of Health and Human Services. Dr. Davis told committee members that the Quadrennial Advisory Council on Social Security was proceeding with its mandate to analyze the fiscal problems of the HI trust fund and was expected to report to Congress by January 1, 1984. Dr. Davis went on to describe the administration's budget proposals that would, at a minimum, delay insolvency for 1 year. These proposals include:

—Medicare part A catastrophic coverage, with change in cost sharing.
—Physician fee freeze.
—Part B premium increase.
—Medicare voluntary voucher.

In response to the Administrator's testimony, several members of the committee expressed concern about the impact of the administration's short-term proposals and raised the question of long-range plans to restrain the increase in hospital costs. Chairman Heinz indicated that it will be important to look at systemwide reforms rather than to approach the problem piecemeal with emphasis on only the medicare program.

The committee also heard from Dr. Joseph Newhouse (Rand Corp.), Dr. Gail Wilensky (NCHSR), and Dr. Karen Davis (Johns Hopkins University), each of whom offered guidelines for future financing decisions and recommended possible ways of restoring solvency to the HI trust fund. Each of the witnesses emphasized that policymakers should not look on older Americans as a homogeneous group. Among the elderly, there is a broad range of income, health status, use of medical services, and per capita health expenses. Of the 26 million aged medicare beneficiaries, between 20 and 25 percent are poor or near poor. While elderly persons with only medicare insurance are able to obtain health care, that care often comes at substantial financial cost to the individual. It already appears that those without supplementary insurance use fewer physician, drug, and hospital services. Absorbing additional out-of-pocket expenses from increased cost sharing is likely to be difficult for them, and to further decrease their access to care.

Dr. Karen Davis described the variability in service use among older Americans. In 1977, 77 percent of the elderly had virtually no hospital expenses under medicare, while 9 percent of the elderly accounted for 70 percent of medicare hospital expenditures for the aged. Dr. Davis recommended two options for consideration. First, tightening up rates of increase in payments to hospitals under the prospective payment plan. Second, merging the part A and part B programs and trust funds and replacing the present part B premium with an income tax surcharge on medicare beneficiaries, which she proposed as a "more equitable way of financing the deficit than loading up charges on elderly who are hospitalized."

Each of the witnesses urged committee members to consider a broad range of options, with careful attention to costs, administrative efficiencies and, most importantly, distributional impact on persons according to their income and health status.

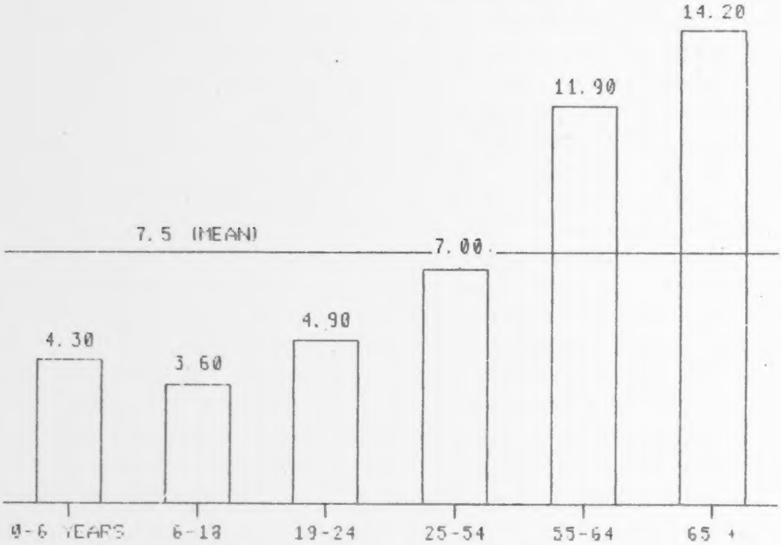
The hearing set the stage for further discussions on the future of medicare.

### (C) "DRUG USE AND MISUSE"

On June 28, 1983, the Senate Special Committee on Aging and the House Select Committee on Aging met for a hearing, "Drug Use and Misuse: A Growing Concern for Older Americans." This hearing was the first thorough congressional oversight of the problems associated with prescription and nonprescription drug use among persons over age 65. The hearing, chaired jointly by Chairmen John Heinz and Claude Pepper, provided a forum for discussion from a variety of experts, including patients, pharmacists, doctors, consumer advocates, and the Food and Drug Administration.

Drug misuse is of special concern to older persons who purchase 70 percent of all over-the-counter (OTC) drugs and between one-fourth to one-third of all prescription drug purchases. Approximately 75 percent of persons over age 65 use at least one prescription drug annually. Of those individuals, the average number of drugs used was 14.2. This compares to the general population, where approximately 58 percent used at least one prescription drug and an average of 7.5 drugs annually.

NUMBER OF PRESCRIBED MEDICINES USED IN A YEAR



Source: U.S. Senate Special Committee on Aging, Drug Use and Misuse, June, 28, 1983

Drug use increases with age because of the increased incidence of disease, both acute and chronic. More than four-fifths of the elderly population suffer from at least one chronic condition, and many suffer from multiple chronic conditions. The combination of multiple chronic diseases and treatment with multiple drugs leads to a high incidence in the elderly of adverse drug reactions and interactions. While adverse drug reactions and interactions account for approximately 3 percent of all hospital admissions, they account for 12 to 17 percent of hospital admissions for those between 70 and 90 years of age. According to the General Accounting Office, approximately 40 percent of those suffering from adverse drug reactions are over 60 years old.

Drug misuse among older Americans is to some extent attributable to noncompliance. Drugs are not always taken as prescribed. The problem is more pervasive among the elderly because many live alone and are required to adhere to a complicated drug regimen. The difficultly is compounded by impaired hearing function (the patient may not understand the pharmacist's or physician's instructions and is embarrassed to ask that they be repeated), or impaired vision (the patient may have difficulty reading the instructions on the label and may not be able to differentiate between medications), and increased forgetfulness ("Did I take my pill this morning?").

Intentional noncompliance also increases the incidence of misuse. Many patients, for example, do not take a drug as prescribed if they do not "like" the effect or if they feel the drug may be unnecessary. Child-proof containers can also be a problem. It may be difficult, for example, for persons with arthritis to open the container. Many patients do not realize that they can ask their pharmacist to put the medication in another container that will be easier to open.

The hearing focused on four principal issues. First, drug consumers tend to know very little about the drugs they take. A recent FDA survey indicated that 58 percent of patients of all ages received information on how to take their medication properly, but 75 percent received no information regarding potential side effects. Only 2 percent of patients regularly asked their physicians for information. Moreover, there is an absence of useful, easily read, and easily accessed information to guide safe use of drugs.

Second, there is very little information that is gathered and made available to physicians concerning the effect of drugs on older users. Although the pharmaceutical industry is currently required by law to gather information concerning the appropriate dose levels, side effects and special instructions for infants, children, and nursing mothers, there is no comparable requirement that would provide relevant information concerning older drug users, even though older persons use, on average, more drugs than persons in other age groups. Witness Peter Lamy, director of the Center for the Study of Pharmacy and Therapeutics for the Elderly at the University of Maryland noted that the elderly take 79 percent of all antiarthritic drugs that are being used, and 86 percent of all cardiovascular drugs, yet

> * * * We know very little about these drugs. Drug use in heavy, and we know extremely little of drugs that are given for prolonged periods of time. We know even less when drugs are given in a complex therapeutic regimen. We test drugs in young people for 3 months; we give them to old people for 15 years. Elderly patients tend to respond to drugs much more individually than do younger patients, and the average findings we get from studies are often not applicable. Drugs are usually tested in comparatively healthy populations.

The problems that arise from inadequate information about particular drugs on older consumers is exacerbated by the inadequate training of most physicians in geriatric medicine. Chairman Pepper told committee members:

> * * * only about 10 to 15 of the 127 certified medical schools in the country require their students to take geriatrics, so that a lot of the doctors are simply not adequately informed about the elderly and the reactions (to drugs) in the elderly.

Mike Flaherty, a witness from St. Francis Hospital in Pittsburgh, added:

> Fully 75 percent of the medications on the market today were not on the market when 50 percent of the doctors practicing today were in medical schools.

The difficulty in prescribing correctly is compounded when physicians don't know what drugs, either prescription or nonprescription, are being taken by their patients. Dr. Jonathan Lief, a geriatric specialist from Tufts University told the panel:

> * * * the elderly often need specialists, sometimes multiple specialists. In addition, many elderly shop around for doctors. So they end up with two, three, four, five doctors * * * all prescribing two, three, four medicines, and no one is coordinating the various treatments.

A third issue examined by the committee involves postmarket surveillance. Although FDA has a mechanism in place for postmarket surveillance, there is evidence that information is not cycled back to consumers, pharmacists, and physicians promptly to prevent misuse. Moreover, according to the General Accounting Office, in 1982, approximately 42 percent of all adverse drug reactions were not known to the Food and Drug Administration.

Fourth, the Food, Drug, and Cosmetic Act requires that minimum information be included on the prescription label received by the patient/customer. Labels are required to show the name and address of the dispenser, the name of the prescriber, the serial number, and the date of prescription and if stated in the prescription, the name of the patient, directions for use, and any applicable cautions. Additional requirements are regulated by each State, and vary considerably. Consequently, older drug users with multiple prescription drugs on their shelves may have no way of knowing which drugs are for which conditions, for example, or when the drugs in their medicine cabinets could become inactive or toxic.

In response to several of the issues raised over the course of the hearing, Dr. Mark Novitch, Deputy Commissioner of the Food and Drug Administration, described some of the Administration's initiatives to combat misuse, including a patient education insert that accompanied all social security checks that was sent to beneficiaries in July 1983, advising patients to ask physicians and pharmacists more questions about the drugs they take and also to send away for a brochure. Dr. Novitch also spoke of the FDA's Committee on Patient Education, which was established in January 1982: (1) To coordinate Government efforts to advise consumers about prescription drugs, and (2) to serve as a catalyst for private sector initiatives. FDA is also drafting guidelines for manufacturers to test drugs on older consumers prior to marketing.

In his concluding remarks, Senator Heinz said:

> The message that came through loud and clear is that we have a real information gap—a real dearth of information about what drugs the elderly take, how these drugs react and interact in an older body, and what side effects these drugs cause. Consumers, doctors, pharmacists, drug manufacturers—we're all in the dark. And we've paid a tremendous price for our ignorance in the emotional and physical agony of our older citizens. We need information and we need it fast.

### (D) "HOSPITAL COST CONTAINMENT: STATE, LOCAL, AND PRIVATE SECTOR APPROACHES"

On October 26, 1983, the committee held a hearing on State, local, and private sector hospital cost-control programs. The hearing purpose was to assess the extent to which these non-Federal initiatives can be expected to bring the Nation's spiraling bill for hospital care under control.

As Chairman Heinz noted in convening the hearing:

> The excessive growth rates of health care costs are spreading systemically, like cancerous growth, throughout the health sector. They threaten the health and productivity of other sectors of our economy. To control medicare costs over the long term, it now appears that we may need to restrain health care costs across the board. If we do not, not only will medicare face bankruptcy by the end of this decade, but by the year 2000 annual medical costs will average over $2,500 in 1983 dollars for every man, woman, and child in America.

Committee members learned that a recent Lou Harris survey found three out of four Americans believing that fundamental changes are needed in the Nation's health care system, and that the main reason that people feel this way is their perception that health care costs are out of control.[1]

At the State level, one approach to cost containment is the application of statewide controls on hospital rates or revenues, an approach known as "all-payer programs" because the State controls the rates or amounts paid to hospitals by all health insurers, public and private. Four States now use this approach—Maryland, Massachusetts, New Jersey, and New York. An all-payer program can yield a meaningful reduction in the growth rate of hospital costs within a State when there is strict regulation of hospital rates or total annual hospital revenues. The business community in a number of States is interested in all-payer programs, because they promise to hold down the ever-increasing amounts which employers are having to pay for their employees' health insurance. The all-payer model can also be adopted by a region smaller than a State. Two regions within New York State are demonstration sites for testing the regionwide prospective budget as a means of controlling hospital costs. Each region's hospitals are jointly committed to financing all of their annual operating costs within this budgeted amount.

States, regions, communities, and the private sector have developed other kinds of hospital cost-control programs. Most of these programs make use of some form of prospective reimbursement, and all of them bring new management or organizational structures to the provision of health care. Health maintenance organizations (HMO's) and prudent purchaser organizations (PPO's) are two examples of this approach. PPO's are a new concept which has been developed further in California then anywhere else. For example, Blue Cross of California contracts with a hospital and its admitting physicians who agree to provide cost-efficient care; Blue Cross is then able to reduce its insurance premiums to those beneficiaries who agree to obtain their care from these contracting hospitals and admitting physicians.

---

[1] The Equitable Healthcare Survey: Options for Controlling Cost. August 1983. pp. 3–5.

From the information presented at the hearing, it is clear that these non-Federal initiatives are able to control costs for States, localities, or health-care purchasers who use these cost-control methods, but at present they are in effect for only about a quarter of the country's population. It is not clear that they will be adopted on the wide scale needed to nationally constrain the rate of growth in health care costs.

## 2. FIELD HEARINGS

### (A) "COMMUNITY ALTERNATIVES TO INSTITUTIONAL CARE"

On July 6, the Senate Special Committee on Aging held a hearing in Harrisburg, Pa., entitled "Community Alternatives to Institutional Care." The hearing examined issues related to the deinstitutionalization of mentally retarded and elderly persons, and reviewed the Federal role in promoting alternatives to institutional care. Witnesses included Walter Cohen, the secretary of the Pennsylvania Department of Public Welfare; David Eisenberg, director of the Philadelphia Channeling Demonstration Project; and Richard Browdie, deputy director of the Philadelphia Corp. on Aging.

In the past decade, an effort has been made to transfer the mentally ill, the developmentally disabled, and the elderly from institutions to community-based settings. This movement occurred for two significant reasons. First, a number of medical, pharmaceutical, and therapeutic treatments were developed which enable frail elderly and severely disabled persons to care for themselves with appropriate support from community care facilities. Second, a series of court decisions in the early 1970's prompted States to empty their institutions and move residents into community-based facilities, such as boarding homes.

Many of these community-based facilites, however, were unable to provide the appropriate level of care for these persons. Reports of untreated gangrene, dehydration, and malnutrition surfaced across the Nation. In response to these problems, in 1976 Congress enacted the "Keys" amendment to the Social Security Act, requiring States to license and regulate boarding homes. The amendment also authorized the Department of Health and Human Services to withhold patients' SSI checks ordinarily transferred to the home for care of the resident, if the home did not meet minimum standards.

The Federal Government has taken various approaches to promote alternatives to institutional care. In fiscal year 1980, Congress made an appropriation for HHS to establish the national channeling demonstration program, which allowed States and local agencies to develop, coordinate, and manage long-term care services in a community-based setting to persons who would ordinarily be admitted to a nursing home.

John Swain, whose mother received services through the Philadelphia channeling project, told Chairman Heinz:

> Mom would not have lived as long as she did had she been in another setting. It is organizations such as the channeling project that prolonged her life, and yet made her happy as well as comfortable.

Mr. Browdie told the committee that community-based settings are not appropriate for all older persons, and that alternatives to institutionalization should maintain a strong interrelationship with nursing homes in order to function effectively. He also stressed the need for flexibility in Federal long-term care initiatives to enable local administrators to establish suitable standards based on their particular needs and resources.

The hearing also examined the implications of draft legislation (later introduced as the Community and Family Living Amendments of 1983—S. 2053) which would shift the flow of Federal medicaid dollars from institutional settings to community-based alternatives for the mentally disabled. Several witnesses, including those with severely retarded children, differed as to the merits of this legislation. Senator Heinz said he favored a cautious approach to deinstitutionalization, in which placement would be based on medical criteria and the availability of community support services.

The Senator added:

> I don't happen to believe that all State institutions should be closed. But for those residents confined to institutions with a documented history of patient abuse, I think we must move quickly to find more suitable living arrangements. Clearly, we need a coherent Federal policy in the future directions of deinstitutionalization.

### (B) "THE ROLE OF NURSING HOMES IN TODAY'S SOCIETY"

This hearing, chaired by Hon. Larry Pressler, and held in Sioux Falls, S. Dak., on August 29, 1983, identified problems which nursing homes face in conforming with Federal regulations. Witnesses testified that staff members spend many hours completing burdensome paperwork when they could be providing quality care to their patients. Testimony from nursing home specialists in rural communities highlighted the specific problems they face in acquiring needed consultants.

The second panel of witnesses focused their testimony on the effects of Alzheimer's disease and the need for increased research funding. Answers are needed in order to find an adequate means of diagnosis and treatment. The success story of the local chapter of the Alzheimer's Disease and Related Disorders Association was also highlighted. Witnesses testified that this group offered excellent support to the families of Alzheimer's patients. The nursing home and adult day care needs of the patient with Alzheimer's disease were also discussed.

### (C) "ENDLESS NIGHT, ENDLESS MOURNING: LIVING WITH ALZHEIMER'S"

Alzheimer's disease is the most common cause of dementia, the clinical syndrome referring to progressive intellectual impairment. According to the best available estimates, Alzheimer's disease affects over 5 percent of Americans over age 65, and more than 20 percent of those over the age of 80. Approximately 120,000 people die of Alzheimer's each year, making it the fourth leading cause of death in the United States. The course of the disease is progressive and irreversible, beginning with simple forgetfulness, followed gradually by noticeable and then severe changes in memory and personality. The cause of Alzheimer's is not known, and a positive diagnosis is usually made only after other causes of dementia, such as alcohol intoxication, brain tumor, stroke, or depression have been excluded.

On September 12, 1983, the Senate Special Committee on Aging held a hearing at the Jewish Home and Hospital for Aged in New York City entitled "Endless Night, Endless Mourning: Living with Alzheimer's." The hearing examined the problems in caring for a person with Alzheimer's disease, and reviewed ways to provide appropriate and affordable care for persons with this insidious disease. The hearing also reviewed the progress of research directed at unraveling the mystery surrounding the cause and treatment of Alzheimer's disease.

Senator John Heinz, chairman of the Aging Committee, and Senators Larry Pressler and Alfonse D'Amato heard testimony from family members and support groups, professional caregivers, and policy experts in the field of long-term care. In response to testimony from Dr. Leslie Libow, chief of medical services at the Jewish Home, that more than 50 percent of all those with Alzheimer's disease are cared for in the home, Senator Heinz said he would continue to press for the creation of more appropriate and less expensive community-based support systems and for the initiaton of financial support for custodial care. Senator Heinz referred to three bills he introduced this year which would make it substantially easier to care for older family members in the home: The Home Health Care Tax Credit Bill (S. 1301), the Health Care Coordination Act of 1983 (S. 1614), and the Independent Community Care Bill (S. 1244).

This hearing also called attention to the issue of protecting middle-income families from "spending down" to a poverty level to finance long-term care. Since medicaid pays for long-term care services only for the poor, middle-income elderly are often forced to exhaust their financial resources to purchase the services they require. Medicare will not cover the custodial care services that Alzheimer's patients often require because Alzheimer's disease, unlike cancer, is not considered treatable.

As a followup to the September 12 hearing, Senators Heinz, Pressler, and D'Amato wrote a letter to the chairman of the Senate Appropriations Subcommittee on Health requesting a significant increase in funds for Alzheimer's disease research through the National Institute on Aging. The Appropriatons Committee responded favorably, and the Labor-HHS Appropriations bill for fiscal year 1984 contained over $30 million for Alzheimer's research. The bill included an additional $3.5 million for the establishment of up to five specialized Alzheimer's disease research centers across the country.

### (D) "THE CRISIS IN MEDICARE: PROPOSALS FOR REFORM"

On December 13, 1983, the Senate Special Committee on Aging held a field hearing in Sioux City, Iowa, on the issue of reforms in the medicare system.

Senator Charles Grassley chaired the hearing. Senator Larry Pressler was also in attendance. They heard testimony on the magnitude of the problems facing the medicare trust fund, and the projections as to when the fund would face insolvency. HCFA presented the administration's most recent budget proposals, and its view on broader reform possibilities. CBO outlined three major options for dealing with the problem which served as a basis for discussion on the various alternatives. Those options included changes in the reimbursement to providers, benefit restructuring, and higher taxes.

The panels, consisting of Iowans affected by, and interested in the medicare program, provided testimony on their perception of the problem, and their preferred solutions to restoring fiscal integrity to the trust fund. Many comments were heard on the special problems Iowans face in the area of long-term care, and the shortage of skilled nursing facilities.

Differences of opinion were particularly sharp in the amount of additional burden each major sector should bear in any reform package. All expressed concern with the need to maintain easily accessible, high quality health care. The importance of utilization review was a topic of shared concern, particularly with the implementation of the new prospective payment system for hospitals. Several individuals expressed reservations about this new system, and cautioned Congress to keep a watchful eye on its development.

# Chapter 13

# LONG-TERM CARE

During 1983, Congress continued to address issues associated with the delivery of long-term care. Legislation introduced in both the House and Senate would expand current services and restructure methods of service delivery and financing. Little Federal action was taken, however, to reform what has become one of the most complex and costly problems facing Federal and, to an even greater degree, State public policymakers.

Long-term care, broadly defined, is a range of services available to individuals who, because of a social, physical, or mental condition are unable to handle the tasks of daily living without assistance on an ongoing basis. Long-term care can be provided in an institutional or noninstitutional setting and may include a variety of health and social services, such as nursing home care, home health care, adult day care, occupational and physical therapy, home-delivered meals, and homemaker assistance.

Demographic and economic projections for the cost, need, and availability of long-term care services are sobering. The Bureau of the Census projects that by the year 2000, the group most at risk of institutionalization—the over-85 population—will be 130 percent larger than it is today.[1] And according to projections by the National Center for Health Statistics, the nursing home population of persons 65 years and older can be expected to increase by 80 percent.[2] If these projections prove to be correct, and if the cost of both institutional and noninstitutional services continues to increase as it has in the past, the Nation may expect to confront a crisis in long-term care.

Federal, State, and private health insurance programs are designed to pay primarily for short-term acute care or long-term, continuous (and typically institutionalized) care. Medicaid, the source of about 90 percent of all public funds spent on long-term care, provides coverage for a range of institutional services to low income categorically eligible or medically needy populations. The medicare program, on the other hand, provides skilled services, such as nursing home or home health care for only a limited period of time. It is neither intended nor designed to provide services to those in need of long-term care.

---

[1] U.S. Dept. of Commerce, Bureau of the Census. America in Transition: An Aging Society. Current Population Reports. Special Studies Series P-23, No. 28, September 1983.

[2] Based on the most recent revised estimates of the 1977 population base. Series P-25, No. 917, 1977 estimated. U.S. Dept. of Commerce, Bureau of the Census. Projections of the Population of the United States, 1982-2050 (Advance Report), Current Population Reports, Series P-25, No. 922. October 1982, Middle Series Projections and the National Nursing Home Survey (1977), National Center for Health Statistics.

While there have been some efforts to provide home and community-based services to those in need of long-term care support (an alternative that can be less costly, usually preferred by patients and families, and often the most appropriate kind of care), these initiatives have reached a very small fraction of the long-term care population. Congress and the administration are reluctant at this time to spend additional Federal funds to extend the realm of public support to cover comprehensive noninstitutional long-term care services. As a consequence, the medicare and medicaid programs continue to be structurally biased to support the most costly forms of care. And Federal, State, and personal budgets suffer from the financial burden caused by excessive and inappropriate use of hospitals and nursing homes.

Federal and State governments spend billions of dollars each year on long-term care. Yet individuals in need of care are required to exhaust their personal financial resources before they are eligible for a significant amount of public support. Meaningful reform on the national, State, and local levels will require a broader and more flexible distribution of these expenditures to encourage the delivery of adequate, comprehensive, and affordable long-term care services.

## A. THE PROJECTED FUTURE OF LONG-TERM CARE: DEMOGRAPHIC AND ECONOMIC INDICATIONS

### 1. Projections: The Long-Term Care Population

#### (A) CHRONIC CONDITIONS

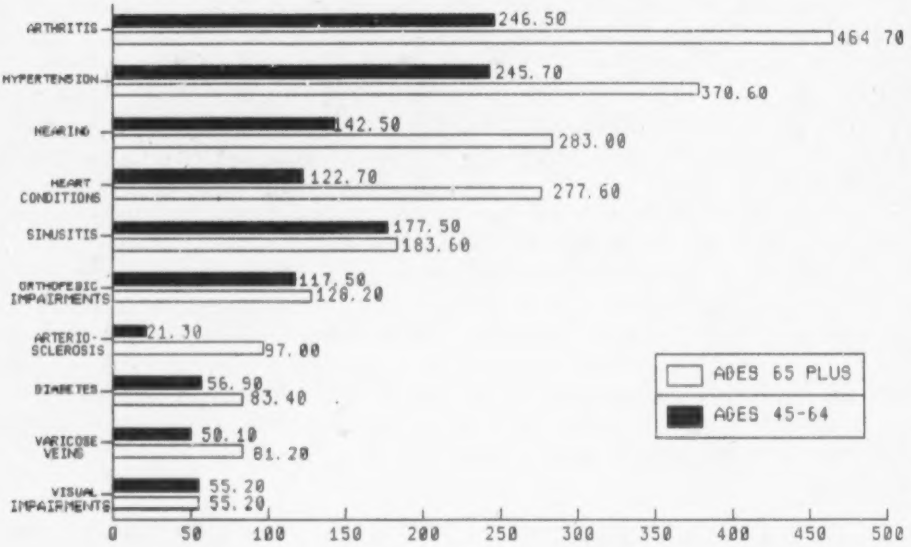
The number of individuals with chronic conditions provides one indication of the potential need for long-term care services; the onset of chronic disease may prevent individuals from functioning independently. Because the incidence of chronic conditions increases with age, the number of those who are likely to require long-term care services by reason of suffering from one or more chronic conditions will also increase.

The pattern of chronic morbidity has changed dramatically in the past 80 years. At the turn of the century, acute conditions were predominant. By contrast today, chronic conditions account for over half the country's disability days for the elderly population. For the 1981 population of men and women 65 and over, the leading chronic conditions were arthritis and hypertensive disease.

Today, many elderly people are hospitalized for chronic conditions rather than acute illnesses leading to death. Digestive conditions, circulatory conditions, and injuries are leading causes of hospitalizations. Most visits to physicians by older persons are for chronic conditions such as circulatory problems, diabetes, arthritis, and respiratory conditions.

CHART 1

MORBIDITY FROM TOP TEN CHRONIC CONDITIONS-RATES PER 1,000 PERSONS
1981



Source: National Center for Health Statistics, 1981 HIS Survey

Heart disease leads all other conditions in each of four major indices of health, accounting for 10 percent of all doctors' visits, 18 percent of all short-stay hospital and bed disability days, and 45 percent of all deaths.[3] Heart disease, cancer, and stroke account for over 75 percent of all deaths among the elderly. These diseases are also responsible for 20 percent of doctor visits and 40 percent of hospital days. Arthritis and rheumatism, the leading chronic conditions, on the other hand, account for relatively few deaths, and only 2 percent of hospital days. However, they account for 16 percent of days spent in bed, nearly as much as for heart disease.

### (B) MENTAL HEALTH

The elderly are frequently described as having the same prevalence of mental health or psychiatric problems as the general public, ranging from 15 to 25 percent of persons 65 years and older. This assumption, however, has been inferred from non-age-specific data. Three recent age-specific studies conducted in New Haven, Baltimore, and St. Louis demonstrate that, for noninstitutionalized persons, psychiatric problems are not constant across age groups.

These studies, sponsored by the National Institute of Mental Health (NIMH), examined 9,000 noninstitutionalized participants to determine the prevalence of specific disorders in the general public. The NIMH project examined seven psychiatric disorders, (affective disorders, panic, and obsessive/compulsive disorders, substance abuse and/or dependence, somatization disorders, antisocial personality disorder, schizophrenia and phobia) and an eighth related disorder, cognitive impairment. Persons 65 and over were found to have the lowest overall rates for all age groups when all eight disorders were grouped together.

---

[3] Health. United States, 1982, U.S. Dept. of Health and Human Services. Public Health Service. p. 36.

While the elderly have the lowest rates for all psychiatric disorders, some mental health problems, such as substance abuse and affective disorders, become rarities in the upper age ranges. Low rates of mental disorders are in part responsible for the fact that older persons use mental health facilities at half the rate of the general population.

The primary mental health problem of older age is cognitive impairment, with rates for mild impairment being substantially higher than rates for severe impairment. The NIMH studies found that rates for mild cognitive impairment were about 14 percent for both elderly males and females. Rates for severe impairment were 5.6 percent for elderly men and 3 percent for elderly women.[4]

Alzheimer's disease affects more elderly persons than any other disease causing cognitive impairment. As recently as 5 years ago, Alzheimer's disease was neglected and little understood by laymen and the medical and scientific community. Through extensive research in this and other countries, considerable progress is being made in advancing understanding about effect, cause, and cure for this disease.

Failure in cognitive functioning is one of the principal reasons for institutionalization of the elderly. Data from the 1977 Nursing Home Survey, the latest data available, indicates that 22.3 percent of nursing home residents had "primary diagnoses" of a mental disorder or senility without psychosis.

Another indicator of mental health problems, suicide rates, although extremely low when compared to other causes of death, are higher for elderly persons than for other age groups. In 1979 and 1981, the suicide rate for persons 65 years and over was about 19 per 100,000 for persons 65 to 74, about 22 per 100,000 for the 75 to 84 age range, and between 14.6 and 16.3 per 100,000 for persons 85 years and over.

### (C) LIMITATION OF ACTIVITIES OF DAILY LIVING

Chronic conditions limit, in varying degrees, a person's ability to carry out the basic activities of daily living, such as eating, bathing, and dressing. For example, one person with arthritis may become housebound, while another only suffers from occasional flareups.

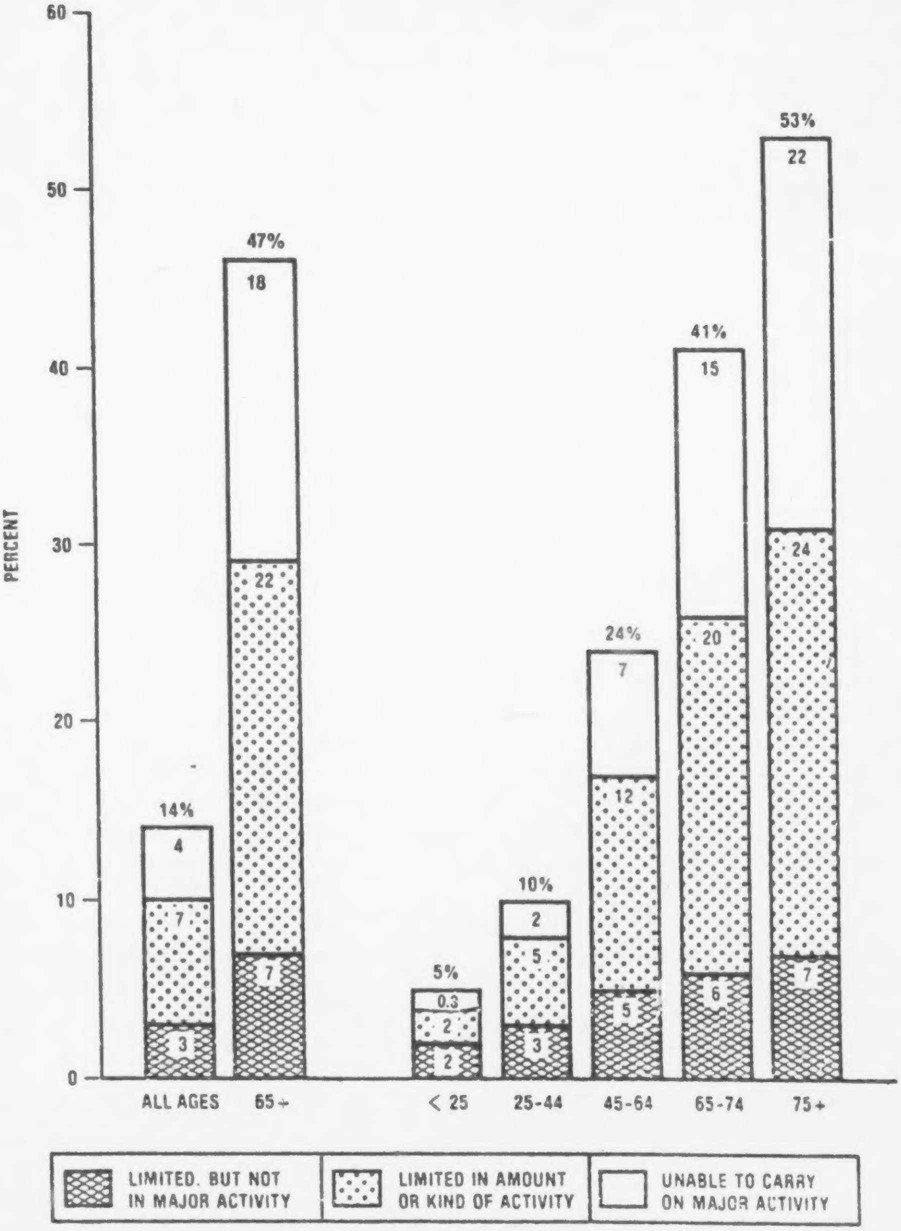
When compared to other age groups in the population, a significantly higher proportion of persons 65 and older are limited in activity due to a chronic condition. However, functional limitations in daily living increase more dramatically for the group over 75 years old; over 50 percent of this age group face serious limitations, with 22 percent so severely limited in activity that they cannot carry on independently.

---

[4] Myers, Jerome K., et al. The Prevalence of Psychiatric Disorders in Three Communities, 1980-82.

## CHART 2

### LIMITATION OF ACTIVITY DUE TO CHRONIC CONDITIONS BY TYPE OF LIMITATIONS AND AGE GROUP—1981

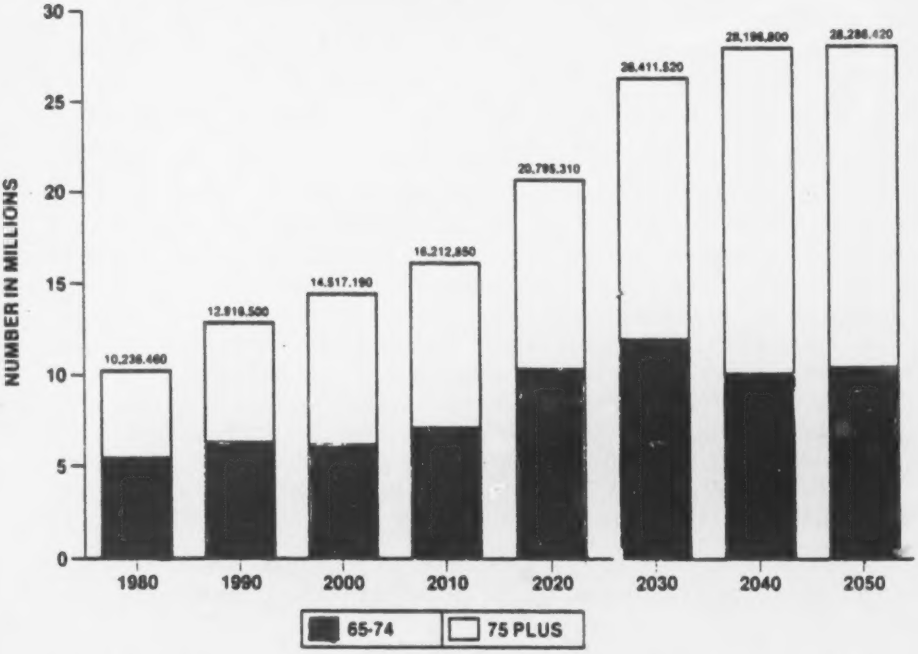


SOURCE National Center for Health Statistics 1981 Health Interview Survey unpublished

Severe effects of chronic illness may prevent individuals from functioning independently and have an impact on the need for future health and long-term care services. In 1980, 10.8 million people over the age of 65 had some degree of limitation in daily activity, from mild to severe, due to chronic illness. Future estimates [5] demonstrate that 14.5 million persons age 65 years or older are expected to have functional limitations at the turn of the century. This figure will reach 23.3 million by the year 2020 and 31.8 million by 2050.

## CHART 3

### LIMITATION IN DAILY ACTIVITY ACTUAL AND PROJECTED PERSONS AGE 65 YEARS AND OVER 1980-2050



SOURCE: Based on 1980 Health Interview Survey, National Center for Health Statistics and Projections of the United States: 1982 to 2050 (Advance Report), Current Population Reports, Series P-25, No. 922, October, 1982. Middle Series Projections.

These projections demonstrate that because of the growth of the population with functional and daily activity limitations, twice as many health and long-term care services as are presently available will be needed by the year 2020.

---

[5] Projections are based on current rates of limitation in daily activity due to chronic illness and U.S. Census Bureau population projections without making assumptions about future changes in rates for limitation of daily activity due to chronic illness in the population.

### (D) NEED FOR ASSISTANCE

The proportion of elderly persons needing help in personal care or home management assistance increases dramatically in the upper age ranges. While only 6.7 percent of persons in the 65 to 74 age range need the help of another person, this figure more than doubles to 15.7 percent for persons in the 75 to 85 year age group and surges to 39.3 percent in the 85 year and older age group. By the same token, 34.84 percent of this age group need help in one or more basic activities, and about a third need help in walking and going outside the home.[6]

Friends, spouses, relatives, and others provide valuable assistance to many elderly persons who live in the community. A little over 60 percent of persons 85 years and older who live with nonrelatives need the help of another person in personal care home management activites. This figure is 48.7 percent for those who live with relatives other than a spouse and 31.9 percent for the extreme aged who live with a spouse. Almost a third of this age group who live alone are in need of assistance.

It is generally estimated that families now provide over 70 percent of all long-term care in this country. Most older people live near at least one of their children and are able to depend on their children's assistance to remain relatively independent for as long as possible. Family support in the past has depended to a great extent on women at home who have had time to care and support their older family members. Due to the expanding full-time participation of women in the work force, their continued ability to attend to the needs of older family members can be expected to deminish in the foreseeable future.

By the year 1995, the Census Bureau estimates the number of widowed, never married, and single divorced will exceed the number of elderly married persons.[7] Consequently, members of the extended family or professional providers will be called upon to compensate for the nonexistent spouse/caretaker. As divorce and single living become more common, single-family members may not have sufficient time, money, or energy to take care of their dependent parents.

## 2. PROJECTIONS: THE NURSING HOME POPULATION, 1980 AND BEYOND

Because the last major nursing home survey took place in 1977, information currently available about the nursing home population is dated. (A new survey is expected to begin in 1985 with data available in 1986.) We do know, however, that during the last two decades, there has been a substantial increase in the number of nursing home residents. In 1963, there were 505,000 individuals residing in nursing homes. By 1977, the number had grown to 1.3 million.

Ninety percent of nursing home residents are 65 years and older; in 1980, 1.2 of 1.3 million residents were 65 years or older. Using current estimates for the nursing home population and U.S. Census Bureau population projections, by the turn of the century, the nursing home population is expected to increase 80 percent to 2.2 million and will more than triple to 5.4 million over the next 50 years.[8]

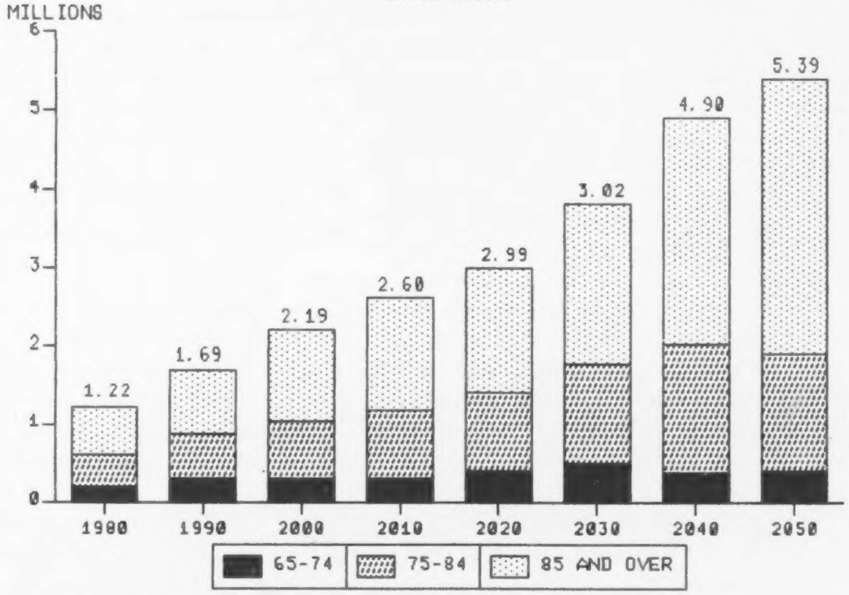
---

[6] National Center for Health Statistics. B. A. Feller Need for Care Among Noninstitutionalized Adults, Draft Paper for Health, United States, 1983.

[7] U.S. Dept. of Commerce, Bureau of the Census. Population Estimates and Projections of Number of Households and Families. 1979–95.

CHART 4

NURSING HOME POPULATION PROJECTIONS
PERSONS 65 YEARS AND OLDER BY AGE GROUP
1980-2050



Source: Based on most recent revised estimates of the 1977 population base, U.S. Bureau of the Census, Series P-25, No. 917-1977, estimated, and Series P-25, No. 922, October, 1982. Middles Series Projections; and the National Nursing Home Survey (1977), National Center for Health Statistics

Although the percentage of older Americans living in nursing homes is relatively small, 4.7 percent, the likelihood of spending some time in a nursing home increases with age. According to the Nursing Home Survey, only 1 out of every 100 persons in the age 65 to 74 age group is in a nursing home on a given day. This number increases to 7 out of 100 persons in the 74 to 84 age group and to more than one out of every five persons in the 85-plus population.

In October 1983, the General Accounting Office (GAO) released its report, entitled "Medicaid and Nursing Home Care: Cost Increases and the Need for Services Are Creating Problems for the States and the Elderly."

---

[8] Based on most recent revised estimates of the 1977 population base. Series P-25, No. 917, 1977 estimated. U.S. Dept. of Commerce, Bureau of the Census; Projections of the Population of the United States, 1982-2050 (Advance Report), Current Population Reports, Series P-25, No. 922, October 1982, Middle Series Projections and the National Nursing Home Survey (1977), National Center for Health Statistics.

Principal findings described in the 172-page report include the following:

—While increased community-based services and preadmission screening may postpone entry into nursing homes for some portion of the at-risk population, they could at the same time result in higher dependency levels and care needs for the elderly people who do enter nursing homes.

—The State spending the most ($274) for nursing home services for each elderly resident spent eight times as much as the State spending the least ($34).

—The Federal medical assistance percentage, designed to compensate for disparities in State fiscal resources, does result in increases in spending for nursing home services in some poorer States. However, even after adding the Federal contribution to each State's spending, overall State nursing home spending variation was reduced by only about 8 percent.

—States varied widely in their bed/population ratios in 1980, from a low of 22 beds per 1,000 elderly persons in Florida to a high of 94 in Wisconsin.

—About half the members of a group identified as highly likely to use nursing home care—individuals who are age 75 or older, unmarried, and dependent in "toiletting" and eating—were in nursing home beds in the District of Columbia and nine States—the jurisdictions with the lowest bed/population ratios. However, about 90 percent of the persons with these same characteristics were in nursing homes in the 10 States with the highest bed/population ratios.

—Regardless of whether States currently have high or low bed/population ratios, several are trying to control their bed supply because of its relationship to medicaid expenditures. This is occurring despite indications that nursing home occupancy rates are high nationally and that the annual growth rate in bed supply has not kept pace with the annual growth rate in the number of the heaviest users of nursing home care (those 85 and older) in recent years.

—Most State reimbursement systems are not designed to pay for the cost of each patient's need for care. Furthermore, many States have revised their reimbursement systems since 1980 in an effort to keep costs down.

—While cost control efforts may produce more efficient care delivery, at the same time they require that States insure, through appropriate mechanisms, that the quality of nursing home care is maintained. Few States have directly linked payment levels to the quality of care provided.

—Patient characteristics and care needs, combined with States' medicaid nursing home and bed supply policies, have helped create an access problem for some medicaid and potentially medicaid-eligible patients in need of nursing home care.

—Recent legislative changes have been made to medicare hospital reimbursement to strengthen hospital incentives to discharge patients sooner. If hospitals respond to these incentives by placing convalescent medicare patients in scarce nursing home beds, problems in placing heavy care medicaid patients may increase. Problems may also occur for patients if they are discharged by hospitals too quickly to nursing homes that cannot provide the level of care they require.

—Improvements are needed in the efficiency with which medicaid nursing home services are provided across the States: The elderly who are in need of long-term care should be assisted to remain in the community as long as possible and economically feasible and the elderly who are most in need of nursing home services should be able to receive them.

—There are major gaps in information on the most basic components of medicaid's support of nursing home care, which caused serious problems in GAO's efforts to assess the program across the States. Data on the care needs of the persons served, patient days, expenditures, beds, and levels of care are generally outdated, unreliable, or unavailable. DHHS has concurred with GAO's assessment of the medicaid program and with GAO's concluding observations on continuing information requirements.

### 3. Economic Projections

The number of individuals requiring some form of long-term care is increasing. The range of available services is expanding. The cost of providing these services has increased over the past few decades and there is every reason to expect a continued upward trend.

The total cost of providing long-term care services in 1983 was estimated to exceed $44 billion—approximately 15 percent of total national personal health care expenditures.[9] This estimate computed by the Health Care Financing Administration includes: (1) Public and private expenditures for nursing homes; (2) expenses for long-term hospitals and estimates of expenses for long-term care provided in short-term hospitals; (3) medicare expenditures for home health care; and (4) the cost of providing care to those who are inappropriately backed up in acute care hospital beds.

The largest proportion of long-term care dollars is spent in nursing homes. In current dollars, total nursing home costs for 1983 were projected to be $29.8 billion, a 9.2 percent increase since 1982.[10] Nursing home costs are increasing faster than the overall rate of inflation.

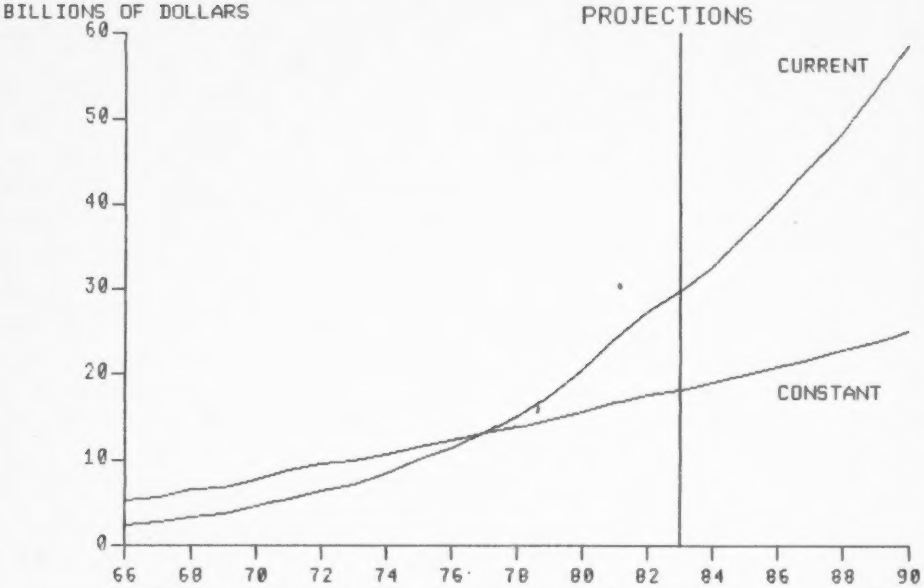
---

[9] U.S. Dept. of Health and Human Services, Health Care Financing Administration. Unpublished data, 1984.

[10] U.S. Dept. of Health and Human Services, Health Care Financing Administration. Unpublished data, 1983.

CHART 5

NATIONAL NURSING HOME EXPENDITURES



Source: HCFA Review, March, 1983 and "Health Spending in the 1980s: Integration of Clinical Practice Pattern with Management, Freeland and Schendler, March 1984, HCFA Review

Discounting inflation, between 1965 and 1985, the cost of nursing home care will have quadrupled. As a percent of real GNP, adjusted for inflation, nursing home costs have doubled from 0.35 percent of the GNP in 1965 to 0.71 percent of the GNP in 1981.[11]

In addition to nursing home care, recent years have witnessed some growth in home health care. For fiscal year 1983, medicare expenditures for home health care were an estimated $1.5 billion. Between 1974 and 1983, medicare outlays for home health care increased from $100 million to $1.5 billion.[12] Even though home health's share of the total long-term care budget remains small (2.6 percent of total program outlays in fiscal year 1983), it has nonetheless become one of the fastest growing components of Federal health expenditures.

## B. LONG-TERM CARE EXPENDITURES

The ability of individuals to make out-of-pocket expenditures for long-term care services is eroding. The exact amount paid annually by individuals and family members is not known. We do know, however, that private payments accounted for 45 percent of the total cost for nursing home care in 1982, and direct payments by patients for 44 percent of the total. At least one-third of these private payers "spend down" and become eligible for medicaid in less than 1 year after admission to nursing homes.[13] Private health insurance covered less than 1 percent of total expenditures for nursing home care.

---

[11] Ibid.

[12] Ibid.

State governments are finding payment for their share of long-term costs an increasing burden. Because the nursing home population is growing and the cost of providing nursing home care is increasing, medicaid has become one of the fastest growing components of State budgets. The medicaid program, the primary source for all public funds spent in long-term care, accounts for about 50 percent of total nursing home expenditures, including both public and private contributions. Of total expenditures reported by States for long-term care in 1980, medicaid paid between 55.5 and 90.7 percent of annual long-term care costs.[14] In many cases, medicaid absorbs between 10 and 15 percent of State operating funds. In an effort to restrain the growth of medicaid expenditures, States are beginning to provide a more appropriate range of less costly services.

According to reports issued by the Intergovermental Health Policy Project, many States have adopted revisions in their medicaid programs to control their continously increasing contribution to long-term care costs.[15] Surveys conducted by the Intergovernmental Health Policy Project and the National Governors' Association found that in 1981 more than 30 States took some action resulting in reductions or limitations on either benefits, eligibility, or provider reimbursement. Approximately the same number of States instituted such cutbacks in 1982. However, the latest survey also noted that some States have also expanded or added benefits or lifted certain restrictions.

In order to control, if not reduce, their portion of nursing home costs, certain States have eliminated or limited the number of nursing home reserved bed days. As many as 26 States made changes in nursing home reimbursement policies to reduce costs during 1981 and 1982. Certain States have put in place some form of preadmission screening to limit nursing home use for medicaid recipients for whom other more appropriate forms of care could be found. Others have adopted proposals that limit or decrease nursing home reimbursement rates, for example, by implementing prospective reimbursement methodologies for nursing homes.

Because long-term care costs are beginning to consume an increasing portion of State budgets, many States are experimenting with various ways in which to spend limited Federal and State dollars.

---

[13] U.S. General Accounting Office. Entering a Nursing Home, Costly Implications for Medicaid and the Elderly. Report to the Congress of the United States by the Comptroller General. PAD-80-12, Nov. 26, 1979. pp. 38-40.

[14] Cohen, Joel. The Urban Institute. Public Programs Financing Long-Term Care. National Governors' Association, Center for Policy Research. January 1983, p. 4.

[15] The Intergovernmental Health Policy Project. George Washington University and State Medicaid Information Center, National Governor's Center for Policy Research. Recent and Proposed Changes in State Medicaid Programs, a Fifty State Survey. April 1983.

## C. FEDERAL PROGRAMS THAT SUPPORT LONG-TERM CARE

The programs which support the majority of long-term care services are funded by medicare, medicaid, title XX of the Social Security Act, and title III of the Older Americans Act. There are portions of other programs which may support long-term care such as congregate housing (discussed in another chapter), but their contribution is relatively small. Efforts to pool the resources of these various programs to create a coordinated, long-term care system for chronically ill persons with multiple service needs have been hampered by the dissimilar eligibility requirements and program guidelines, accessibility difficulties, and the institutionalization bias.

About 40 percent of total State and Federal medicaid costs go to reimburse nursing home care. By contrast, only about 1.7 percent of medicaid dollars and 2.4 percent of medicare's total expenditures are directed toward home health services.

### 1. Medicare: Title XVIII of the Social Security Act

Although medicare provides some coverage for home health, the intent of the program is to provide skilled services to the elderly in their place of residence, rather than health-related social support services for the chronically ill. Services which assist individuals in activities of daily living (i.e., homemaker services and personal care services) are specifically excluded from coverage unless the patient requires some form of skilled care (nursing care, physical or speech therapy) at the same time.

Because medicare's home health services are directed toward homebound individuals in an acute situation calling for temporary care, they do not actually serve as a continuing source of long-term care for the chronically ill elderly.

Medicare provides some coverage for nursing home use. However, the skilled nursing home benefit is restricted to 100 days.

The 1982 Tax Equity and Fiscal Responsibility Act (Public Law 97-248) revised eligibility requirements for skilled nursing facility care. Previous law required a 3-day prior hospital stay before a beneficiary could become eligible for medicare reimbursement for skilled nursing facility care. A provision in Public Law 97-248 eliminated this requirement at such time that the Secretary of the Department of Health and Human Services determines that this measure will not lead to increased costs. The provision allows limitations to be placed on eligibility and the scope of services for persons covered without a prior hospital stay. The Secretary has yet to implement this provision.

### 2. Medicaid: Title XIX of the Social Security Act

The medicaid program provides matching funds to States to finance medical care for low-income persons who are in families with dependent children or who are aged, blind, or disabled.

In contrast to medicare, medicaid benefits can be used to provide a more complete range of services. States are required to provide home health services to medicaid eligible persons who are entitled to benefits in a skilled nursing facility. States also may include a personal care provision under their State medicaid plan to allow for health-related support services when prescribed by a physician and supervised by a registered nurse. Adult day health services, which include medical and social care, as well as transportation, also are permissible.

In States with medically needy programs, individuals may qualify for medicaid in nursing homes because the cost of their basic living needs in the nursing home is considered a "medical" expense, and depletes their income more rapidly. In the 15 States without medically needy programs, some individuals may receive medicaid benefits in nursing homes but not in the community because income levels for medicaid eligibility for outpatient care are more restrictive. Federal law was changed substantially during 1981 to respond to some of these inequities. In that year, Congress provided States an option under their medicaid programs to apply for "2176 waivers" to offer certain home- and community-based services.

Based to a large degree on the Pepper/Waxman Medicaid Community Care Act introduced in the 96th Congress, section 2176 of the 1981 Omnibus Budget Reconciliation Act (Public Law 97-35) authorizes the HHS Secretary to waive medicaid statutory requirements in order to enable a State to cover a wide range of home- and community-based services. Perhaps the major significance of this legislation is that, for the first time, a range of both health and personal care services as well as case management are specifically authorized in legislation, thereby giving legislative recognition to the social as well as the medical aspects of long-term care under the aegis of the medicaid program.

Under the new law, a State can provide home- and community-based services, pursuant to a written plan of care, to individuals who have been determined to otherwise require skilled nursing facility (SNF) or intermediate care facility (ICF) services which would be reimbursed by medicaid.

Services which may be provided (in addition to those already authorized under medicaid) include:

—Case management (defined in the conference report as a system under which responsibility for locating, coordinating, and monitoring a group of services rests with a defined person or institution).

—Homemaker/home health aide and personal care services.

—Adult day health.

—Habilitation services (defined in the conference report as encompassing both health and social services needed to insure optimal functioning of the mentally retarded and developmentally disabled).

—Respite care services (defined in the conference report as those given to an individual unable to care for himself which are provided on a short-term basis because of the absence or need for relief for those persons normally providing such care).

—Other services requested by the State and approved by the Secretary.

Room and board services are excluded from coverage under the waiver. States may set limitations on services provided.

Section 2176 specifies that a waiver granted under this section shall be for an initial 3-year term. At the request of the State, it can be extended for additional 3-year periods unless the Secretary determines that the required assurances have not been met in the preceding period. The newly streamlined waiver process requires the Secretary to act on requests within 90 days of submission. States may obtain waivers to implement these services and the requirement that services be offered statewide may be waived.

As of February 13, 1984, the Health Care Financing Administration received 114 requests from 47 States. Of the 114 received, 67 have been approved, 6 disapproved, 6 withdrawn, and 35 are still pending.

Applications for waivers for medicaid home- and community-based services may be submitted to cover care for the aged and disabled, the mentally ill, and the mentally retarded. Some services that have been approved in accepted applications for the aged and disabled are meals-on-wheels, nonmedical transportation, electrical monitors, emergency response systems, companions, chore services, day care, mental health counseling in the home, housekeeper, hospice, minor home adaptations, and foster home services.

The response of over 90 percent of the States to the section 2176 initiative indicates a strong, concerted effort supported by all levels of government to develop alternatives to nursing home use and to create a mechanism that will assist the elderly and disabled in finding the most appropriate level of care in a system with some cost control.

### 3. Title XX—Social Support Services

The Omnibus Budget Reconciliation Act of 1981 amended the existing title XX program to establish a social service block grant to States. Like its predecessor, the title XX block grant program authorizes payments to States for a wide range of community social services for individuals and families, and has the goals of preventing or reducing dependency, preventing neglect or abuse, and preventing or reducing inappropriate institutionalization. Types of services which may be provided under the program include homemaker services, preparation and delivery of meals, transportation, counseling, and adult day care. Although the goals of the program remain the same and States are free to provide a range of community-based services, previous provisions as to income eligibility and targeting of services to specified population groups were repealed by the 1981 legislation.

The fiscal year 1984 appropriation for the social service block grant program is $2.675 billion, the same level available in fiscal year 1983. While the administration's fiscal year 1984 budget request for the program was only $2.5 billion, the 98th Congress permanently increased the authorization level for the program to $2.7 billion effective in fiscal year 1984 (Public Law 98–135).

### 4. The Older Americans Act: Title III

A variety of home- and community-based services are also available under title III of the Older Americans Act. Under this program, formula grants are made to State agencies on aging for planning, coordination, and advocacy for programs for older persons. Under the 1981 amendments to the act, State agencies are required to spend an "adequate portion" of title III funds on in-home services (such as homemaker, home health aides, visiting, telephone reassurance, and chores), access (transportation and outreach), and legal services. Nutrition services, including congregate and home-delivered meals, are a major component of the program.

Title III of the Older Americans Act enlists State aging personnel in the protection of long-term care patients' rights by requiring that a State agency establish a long-term care ombudsman program to investigate the complaints of institutional residents and monitor Federal, State, and local laws regarding long-term care facilities.

The total fiscal year 1984 appropriation for all Older Americans Act programs is $1.108 billion, with the major portion of funds for the title III program. The fiscal year 1984 appropriation for the social services component of title III is $240.9 million, the same level available in fiscal year 1983. For nutrition services, the final appropriation is $383.6 million. The fiscal year 1984 level for congregate meals is $321.6 million, a $2.5 million increase over its fiscal year 1983 level, and for home-delivered meals, $62 million.

## D. FEDERAL DEMONSTRATIONS

### 1. Social/Health Maintenance Organizations (S/HMO's)

In April 1980, Brandeis University was awarded a 3-year planning and development grant from HCFA to define the operational characteristics of the social/health maintenance organization (S/HMO) model. Brandeis selected agencies to sponsor demonstrations of the model and prepared definitions, data reporting plans, and benefit packages. During the first year, Brandeis developed the size and case mix criteria, an initial benefit package, the scope of medicare and medicaid waivers required to support the S/HMO, and a general estimate of costs based on current national cost and utilization profiles. During the second year, operational specifications were defined, and criteria were developed for test site selection. By early 1982, four sites were selected: Metropolitan Jewish Geriatric Center, Brooklyn, N.Y.; Kaiser-Permanente Medical Care Program, Portland, Oreg.; Ebenezer Society and Group Health Plan, Minneapolis, Minn.; and Senior Care Action Network (SCAN), Long Beach, Calif.

The social/health maintenance organization (S/HMO) is a managed system of health and long-term care services geared toward an elderly client population. The S/HMO will enroll a representative mix of people—from well to significantly impaired. Under this model, a single provider entity assumes responsibility for a full range of acute inpatient, ambulatory, rehabilitative, nursing home, home health, and personal care services under a fixed budget which is prospectively determined.

The S/HMO is financed through monthly premiums paid by medicare and by individual enrollees. For medicaid eligibles, medicare and State medicaid agencies share the premium payments. Enrollees, providers, and public third-party payers share risk under the S/HMO model.

Elderly persons who reside in the target service area may voluntarily enroll through the marketing efforts of the S/HMO provider entity. Once enrolled, clients are obligated to receive all S/HMO-covered services through the S/HMO providers, similar to the operations of a medical model health plan. Because of the limited size of the risk pool and the specter of adverse selection, the long-term care benefit for nonmedicaid enrollees will, at least initially, be limited. Nevertheless, the protection that the S/HMO offers will be significant. At one site, the chronic care benefit will be up to $1,000 per month. In no case is it less than $6,000 per year.

It was anticipated that three S/HMO sites would begin marketing in January or February 1984, and the fourth in the spring of 1984. Operation of the S/HMO will depend upon waiver approval by HCFA and OMB.

### 2. The National Long-Term Care Channeling Demonstration Projects

The Department of Health and Human Services (DHHS) had funded a major demonstration to test the feasibility and cost effectiveness of an alternative community-based, long-term care service delivery concept that integrates health and social services.

The channeling program provides community-based long-term care services to people 65 and older who are functionally impaired, unable to manage the essential activities of daily living (ADL) on their own, and lacking in adequate informal supports. The demonstration projects offer a central point of intake for individuals in need, systematic assessment of their needs, and ongoing case management to arrange and monitor the provision of services. The "channeling" demonstrations test two specific models of organizing community care as alternatives to the current institutionally oriented system. One model is designed to manage services currently available to clients, the other to expand the range of publicly financed services and informal caregivers, and to add cost control features.

Through contracts with the participating States, local agencies in 10 communities around the country were selected to implement the demonstration. Participating States are Florida, Kentucky, Maine, Maryland, Massachusetts, New Jersey, New York, Ohio, Pennsylvania, and Texas.

The design and planning phase of the projects has been completed. The basic case management model is being tested in five sites. All sites began operation in early 1982. Five additional sites where the financial control model is being tested were implemented in May and June 1982. A uniform evaluation of all 10 sites using a randomized experimental design is being conducted during the 4-year demonstration program. The demonstration is scheduled for completion in June 1985. The results are expected to be available beginning in February 1985, with a final report published in September 1985.

## E. STATE AND LOCAL INITIATIVES

With rising costs of institutional care and also the increasing numbers of older persons requiring care, many States are changing the organization, delivery, and financing of long-term care services. To a significant degree, State efforts to divert excessive and costly institutional services have been supported by Federal research and demonstration funds and, more recently, by waivers of current medicaid requirements through the implementation of the section 2176 waiver provisions contained in the Omnibus Budget Reconciliation Act of 1981.

In addition to federally supported initiatives, many States have initiated activities independently for long-term care reform. Cost-containment initiatives include efforts to control institutional access through preadmission and screening mechanisms, reorganization of access to community-based services, and development of tax and other incentives for family care of dependent relatives. Some State projects have developed screening and assessment procedures for those "at risk" of institutionalization in order to evaluate the most effective and least costly care option, given the client's needs. In some cases, screening and assessment procedures are applied to persons prior to entrance in a long-term care facility. To avoid the problem of duplication of services, other projects have reorganized access to community services by providing a "single entry" point for clients.

In March 1983, the University of Arizona Long-Term Care Gerontology Center, which is supported by the Administration on Aging, reported on its 50-State survey trends in legislation and programs in long-term care. The survey uncovered a variety of approaches to community-based long-term care issues, ranging from mandatory preadmission screening mechanisms for persons referred for nursing home care to respite care systems and self-care and disease prevention services. Following are some of the highlights from the study.[16]

*Nursing home preadmission screening.*—The survey found that 16 States had mandatory statewide nursing home screening programs with four or more States planning for such programs in the next few years. Six other States have at least partial screening occurring through State and/or Federal demonstration sites in portions of States.

*Coordinated, community-based programs.*—At least 12 States have developed coordinated community-based programs for the elderly. For example, Oregon passed legislation in 1981 to consolidate components of various State long-term care programs, including those funded by medicaid, the social services block grant, Older Americans Act, and State funds. Similarly, in 1982, California passed long-term care legislation that consolidated a wide range of programs and funding authorities for long-term care. In fiscal year 1982–83, South Carolina implemented a statewide system for assessment and case management for medicaid-eligible clients.

*Subsidies to family caretakers and respite care.*—A number of States are experimenting with innovative ways to finance long-term care by supporting informal family support systems. For example, Florida, Maryland, Maine and New Mexico have implemented programs which provide a subsidy to families who are willing to care for functionally impaired relatives at home. Fifteen States provide reimbursement for respite care to family members caring for older relatives.

---

[16] Long-Term Care Gerontology Center, University of Arizona. Working Paper and Reprint Series. A Survey of Rcent Long-Term Care Initiatives in the 50 States. Tucson, Ariz., March 1983.

*Patient rights.*—The survey found that 11 States have enacted or were in the process of enacting legislation protecting the rights of elderly from abuse and the rights of nursing home residents.

In addition to these initiatives, the Gerontology Center report cited other State developments such as legislative reform on long-term reimbursement, and training and manpower development programs for long-term care.

In hearings before the Senate Finance Committee during the first session of the 98th Congress, representatives from a number of States, presented testimony regarding their respective State initiatives in community-based long-term care. Oregon, for example, developed a comprehensive approach to the financing and delivery of long-term care services. The State has designated the State agency on aging as the sole entity to administer all long-term care programs for the elderly. As a consequence of State initiatives that include a management and assessment process, and a nursing home preadmission screening program, State medicaid costs have been reduced by approximately $1 million per month and the medicaid nursing facility caseload has been reduced by 5.6 percent.

## F. PRIVATE SECTOR INITIATIVES

At Senate Finance Committee hearings in November 1983, witnesses described the lack of financial protection against the costs of long-term care services. Stanley Wallack and Jay Greenberg from the University Health Policy Consortium of Brandeis University observed that in contrast to the acute care sector where, in 1981, medicare and private insurance covered nearly 92 percent of the elderly's hospital bill, insurance covered only 3 percent of the nursing home bill in the same year, 2 percent by medicare and 1 percent by private insurance. The lack of insurance creates catastrophic costs for individuals and leads to the impoverishment of many elderly people and their spouses. Wallack and Greenberg also pointed out that over 44 percent of total nursing home expenditures in 1981—more than $10 billion—was paid out of pocket. This contrasts with hospital costs, where only 3 percent of total spending was out of pocket.

According to Wallack and Greenberg, one of the purposes of the social health maintenance organization demonstration project is to determine the extent to which a single provider entity can assume responsibility for insuring against the costs of a full range of acute inpatient, ambulatory, rehabilitative, nursing home care, home health, and personal care services.

Another witness, Mark Meiners of the National Center for Health Services Research spoke of a potential private market for long-term care insurance. He indicated that many of the barriers thought to preclude long-term care insurance can be resolved. According to Meiners, wider availability of private insurance for long-term care has the potential for relieving many of the problems associated with the catastrophic nature of long-term care expenses:

Consumers with private coverage would be protected from "spending down" to go on medicaid. Access to care for the privately insured may be improved because providers view private-pay patients as preferable. In addition, government payers could benefit if private insurance replaces medicaid for the middle class, or at least slows down or negates the incentive to divest assets. For all these reasons, Meiners maintains that continued efforts to support the development of a private market for long-term care insurance are warranted.

Bruce Jacobs and Bill Weissert, witnesses at the Senate Finance Committee hearing "Long-Term Care," testified on the possibility of using home equity to finance long-term care. Such an approval could allow elderly homeowners to remain in their homes while using their asset value to remove the threat of catastrophic long-term care health care costs. According to the witnesses, almost a third of the aged persons who have home equity could afford to buy a large measure of home health care each year for the rest of their lives. Among those at highest risk of needing such care, almost half could afford such care from their equity each year. Furthermore, an estimated 80 percent of all homeowners could afford the annual premiums on an insurance policy which would pay for catastrophic nursing home care should it be needed.

## G. LONG-TERM CARE: LEGISLATIVE AND REGULATORY ISSUES FOR 1984

### 1. Nursing Home Survey and Certification

In many respects, 1983 was a "watershed" year in the history of nursing home regulation. The year began in the wake of significant defeats for DHHS proposals to revise regulations and reduce funding for the joint State-Federal nursing home survey and certification system. Chairman Heinz, at a July 1982, Special Committee on Aging hearing, informed DHHS representatives that there was "zero support" for the Department's proposed deregulation of nursing homes. All 15 members of the committee signed a letter to Secretary Schweiker urging the administration to withdraw the proposed regulations. In October 1982, an amemdment to Public Law 97-276 extended the imposed moratorium blocking DHHS from revising the regulations through July 1983.

The congressional moratorium contained language directing DHHS to consult with Congress, the General Accounting Office, groups representing nursing home residents, States' survey and certification agencies, and nursing home providers, prior to resubmitting the regulations. By February 1983, DHHS had still made no attempt to consult with most of these parties.

Concerned that the moratorium was half over and none of the mandated consultations with consumers had begun, the National Citizens' Coalition for Nursing Home Reform (NCCNHR) invited all parties to meet and discuss fundamental improvements to the regulatory system. The NCCNHR organized five working sessions, the first occurring in April and the remainder running through July, covering issues ranging from the format and frequency of surveys to reimbursement. These working sessions included HCFA, State regulators, provider associations, and a variety of consumer groups, who began to reach agreement on the objectives appropriate for the regulatory system. The NCCNHR sessions culminated with a presentation to DHHS, in September, of a 130-page "Consumer Statement of Principles," intended to guide government in evaluating and implementing its regulatory policy.

On May 12, 1983, Congressmen Waxman, Dingell, and Pepper introduced a revised version of an earlier legislative proposal. H.R. 2997 directed the Institute of Medicine to form a National Commission on the Regulation of Nursing Homes to study the regulatory system and make recommendations for change. This bill was dropped in June, when an agreement was reached with HCFA whereby HCFA would: (1) Only change regulations for skilled nursing facilities (SNF) and intermediate care facilities (ICF) if consumers, providers, and State and Federal regulatory agency representatives all agreed to the change; (2) contract for a study of the survey and certification system, most likely with the Institute of Medicine (IOM); and (3) make any changes in regulations resulting from negotiations with consumers, regulators, and providers subject to revision based upon the findings of the HCFA-funded study.

In mid-May, seemingly influenced by the threat of legislation, the approaching end to the moratorium period, and the NCCNHR working sessions, Carolyne Davis, Administrator of the DHHS Health Care Financing Administration, had begun to invite persons and organizations concerned with the regulatory system to meet and "see if some compromises can be reached by HCFA, providers, and consumers." These Government-sponsored negotiations, including for the first time representatives of all parties affected by the regulatory system, continued through the end of the year, with more scheduled for 1984.

The conflicting trends reported by GAO, together with medicare hospital reimbursement reform, promise to effect major changes in who utilizes the health care continuum and in what kind of setting. These changes will challenge policymakers' ability to insure access to quality care in nursing homes. Consumer participation in high-level policy deliberations, won in 1983 after more than 2 years of organizing and education, represents a fundamental, new and positive development in support of a coherent nursing home regulatory system.

## 2. LONG-TERM CARE LEGISLATION

Concern about the rising costs of long-term care and the relatively imbalanced support for institutional care has prompted introduction of legislative reforms during the first session of the 98th Congress. Although previous Congresses have looked into some of these same issues, there is now mounting interest to control costs by targeting services more precisely, while at the same time expanding the range and scope of available community-based services. While the precise manner in which to accomplish these objectives remains undecided, legislation was introduced in both the House and Senate designed to improve the delivery of long-term care.

As a package, these bills incorporate the most current standards and premises of federally supported research and demonstration efforts. Each of the bills attempts to expand the scope of services provided and extend beyond tests the effectiveness of new cost-control systems. For example, federally supported research during the 1970's pointed to the pivotal role of case management and assessment techniques in targeting services to persons who would otherwise be institutionalized as a means to control nursing home use. This concept underlies the Department of Health and Human Services national long-term care channeling demonstration program which has further developed the concepts of precise targeting and preestablishing cost control mechanisms on expanded benefits. The long-term care bills all incorporate some method to target services.

Other research (social HMO's) has pointed to the potential for long-term care services to be supported by a fixed annual prepaid capitation amount as an alternative to fee-for-service reimbursement mechanisms. At the same time, the legislation recognizes and reinforces the extensive accomplishments of a number of States and localities in developing community-based long-term care systems.

The legislation introduced in 1983 offer a variety of financing mechanisms and benefit packages, ranging from block grants, to new medicare benefits, to tax credits, to pooled, capitated medicare and medicaid payments. Senators Heinz, Hatch, Packwood, and Bradley introduced S. 1614, the Health Care Coordination Act of 1983, which would allow States to implement comprehensive and coordinated programs of acute and long-term care for persons eligible for both medicare and medicaid. The bill would permit States to provide expanded home- and community-based services and to combine the existing medicare and medicaid benefits under one program for persons choosing to enroll. Senator Heinz explained:

> Congress spends billions of dollars each year providing health services through medicare and medicaid—yet often these programs fail to offer beneficiaries the level of care they need. The delivery of long-term care is marred by both the inadequate availability of home- and community-based services and also perverse incentives in the medicare and medicaid programs to use costly and often inappropriate institutional services. S. 1614 addresses the critical need for reform: It allows States to create programs to provide appropriate and cost-effective services that are responsive to the needs of the chronically ill.

States are given the incentive to discourage overutilization of acute hospital care and to offer enrollees the most appropriate kind of services. Another bill, S. 1244, introduced by Senators Packwood, Bradley, and Heinz would amend title XVIII of the Social Security Act to establish a statewide prepaid capitation program for acute and long-term care services for medicare-eligible persons. The program would begin in four States for a 4-year period. Another approach, S. 1539, the home- and community-based service block grant, introduced by Senator Hatch, would create a block grant for home- and community-based care and would authorize funds to States for planning and expanded service delivery. Key elements of these proposals are requirements for targeting services to specified groups through case management and assessment systems. And, as in previous Congresses, a number of bills have been introduced to create tax incentives for families caring for dependent relatives. In the Senate, Senator Heinz introduced S. 1301, a bill to provide tax credits to families for expense incurred in the care of a family member who is over age 75 or who has Alzheimer's disease. S. 888, the Economic Equity Act, also introduced in 1983, among other items, would revise the tax credit for dependent care. Senators Heinz, Glenn, Burdick, Cohen, Kassebaum, and Melcher sponsored this legislation.

In addition to these bills, legislation was introduced to address a problem in the administration of medicare's home health care benefit. According to various home health agencies and medicare beneficiaries, certain fiscal intermediaries which administer medicare's home health benefit have applied more restrictive standards to the Health Care Financing Administration's policy on the extent to which home health care can be provided on a daily basis. According to these home health agencies, some intermediaries are denying reimbursement for "intermittent" care even when certified as medically necessary, because of the Health Care Financing Administration's revised definition of the "intermittent" care standard. H.R. 3616, introduced by Congressman Waxman, would specify that medicare's intermittent home health care benefit can include care on a daily basis for up to 90 days.

Following is a description of major bills addressing these long-term care issues in the first session of the 98th Congress.

## S. 1614 (HEINZ ET AL.), HEALTH CARE COORDINATION ACT OF 1983

S. 1614 amends title XIX of the Social Security Act (medicaid) to authorize any State, subject to the approval of a waiver of medicaid requirements by the Department of Health and Human Services, to establish as a component of its State plan a comprehensive program of acute care and community-based and institutional long-term care services. The program is not required to be offered on a statewide basis.

### ENROLLMENT

Persons eligible for coverage under the program are those who are eligible for both medicare and medicaid (with the exception of those with end-stage renal disease). Enrollment in the program is optional although an individual who chooses to enroll shall not remain eligible under the medicaid State plan or under medicare. No more than 25 percent of the total number of individuals enrolled in the program can be inpatients in a skilled nursing or intermediate care facility, and the percentage of the disabled or frail elderly enrolled in the program must approximately represent the proportion of disabled or frail individuals eligible for both medicare and medicaid in the total population.

### SERVICES

Programs established under the bill are required to provide at least the following services: All services for which payment would be made under medicare; all medical assistance which an individual would otherwise receive under the State medicaid plan; case management services, including assessments and periodic reassessments; homemaker, home health aide, and adult day health care services to the extent that the State determines that the eligible enrollee needs such services; any other community-based services necessary to enable an enrollee to remain in the community.

### FINANCING

Directs the Secretary to make payments to a State on a per capita basis for each individual enrolled in the program. Provides that the amount of such payment be 95 percent of the adjusted average per capita cost (AAPCC) as determined for the purposes of health maintenance organization reimbursement for parts A and B of medicare for the nonfrail. Provides that the Secretary will reimburse the State at 95 percent of the institutionalized AAPCC for: Any individual who is in a skilled nursing facility (SNF) or an intermediate care facility (ICF) or an individual who has been determined to require the level of care in a SNF or ICF if the individual did not receive home- or community-based services, and is dependent on personal assistance on a daily basis for at least two of the following activities—eating, bathing, use of the toilet, transferring to and from bed, or dressing. Requires the State to pay the medicare part B premium for each individual enrolled in the program.

Provides that a State may pay providers of services under the program by any of the following methods: A prepaid capitation payment arrangement with health maintenance organizations or competitive medical plans which meet medicare requirements; a negotiated payment method and rate which is reasonable and adequate to meet the cost of quality care as defined by title XIX (medicaid), or a reimbursement system in accordance with provisions under medicare for medicare-covered services, and for payment in accordance with provisions of the medicaid State plan for services not covered by medicare.

### WAIVERS

The Secretary of the Department of Health and Human Services is authorized to grant a waiver of medicaid and medicare requirements to any State if the State provides assurances that the total cost to the Federal and State governments will not exceed the total cost which would have been incurred if the program were not in effect and that quality of, and access to, health care will be maintained. Permits a waiver of the skilled care, intermittent care, and homebound requirements for the provision of home health care under medicare; the skilled care and posthospital requirement for extended care under medicare; requirements relating to State coverage, comparability of services, and freedom of choice of providers under medicaid; medicaid and medicare reimbursement requirements; and other medicare and medicaid requirements as to amount and duration of covered services, enrollment fees, premiums, deductions, and cost sharing. Waivers may be granted for and are renewable for additional 3-year periods.

Requires that the State provide for periodic quality assurance reviews of any program established by the bill.

Requires States to report to the Secretary at least annually. Requires the Secretary to submit an interim report to Congress 1 year after enactment and another report 3 years after enactment, including an evaluation of the program's effectiveness.

The bill was introduced and referred to the Committee on Finance on July 23, 1983.

### S. 1244 (PACKWOOD ET AL.)/H.R. 3710 (HARKIN ET AL.), H.R. 3838 (RANGEL), SENIOR CITIZENS INDEPENDENT COMMUNITY CARE ACT

Amends title XVIII of the Social Security Act (medicare) to authorize States to establish a statewide prepaid capitation program for providing acute and long-term care services for individuals aged 65 or older who require long-term care by reason of impairments which restrict daily living activities. Limits to four the number of States which may establish such a program during the 4 years following enactment. Authorizes the Secretary of HHS in subsequent years to limit the number of additional States which may establish such a program in order to insure that additional programs will not require payments from the Federal hospital insurance trust fund in excess of the amounts available in the trust fund.

#### SERVICES

Provides that each eligible individual shall be entitled to the following benefits: (1) All services to which such individual would be entitled under title XVIII; (2) homemaker-home health aide services; (3) adult day services; (4) respite care services for up to 14 days or 336 hours in any calendar year; (5) service coordination; (6) preadmission screening and assessment; (7) intermediate care facility (ICF) services for up to 20 days annually, but the number of days of extended care services to which an individual would otherwise be entitled for any spell of illness be reduced by the number of ICF days provided; and (8) such other services as the Secretary may determine. Services provided under the program shall be in lieu of any payments or services to which an individual would otherwise be entitled under title XVIII or under any other federally funded program.

#### ELIGIBILITY

Makes eligible any individual who: (1) Is entitled to benefits under part A (hospital insurance) of title XVIII and enrolled under part B (supplementary medical insurance) of title XVIII; (2) has attained the age of 65; (3) resides in a State with a program; (4) agrees to participate in the program; (5) is not in an institution; (6) is certified by a preadmission assessment and screening team (PAT) to have an unmet need for certain services; and (7) has certain levels of physical or mental impairments which restrict activities of daily living.

Directs the Governor of each State having a program to designate the State agency or agencies which shall administer the program. Directs such agency or agencies to coordinate the designation of entities which shall provide services under the program. Makes such entities responsible for establishing PAT's and providing services under the program. Requires the Secretary to determine the compositions of the PAT in order to assess the effectiveness of different compositions, but specifies that each PAT consist of at least: (1) one physician or registered nurse or nurse practitioner or physician assistant, and (2) one social worker.

### FINANCING

Requires the Secretary to pay a fixed per capita fee to each designated entity for services for which payment may be made under the program. Fees could not exceed an amount equal to 60 percent of the average monthly rate in such State for services provided in freestanding skilled nursing facilities. Requires fee amounts to reflect urban and rural differentials and to be adjusted annually to reflect changes in costs.

Requires an individual receiving services under the program which are otherwise covered services under parts A or B of title XVIII to pay the entity providing the services a copayment equal to the amount which such individual would be required to pay under parts A or B for the same services. Requires an individual receiving homemaker-home health aide services, adult day services, respite care services, or a preadmission screening and assessment to pay a copayment equal to 20 percent of the reasonable charge for such services. Prohibits an eligible individual from being required to make copayments which in any year exceed a specified percent of the individual's income for the preceding year.

The Senate bill was introduced and referred to the Committee on Finance on May 10, 1983. H.R. 3710 was introduced on July 29, 1983; H.R. 3838 was introduced on August 4, 1983. Both bills were referred to the Committee on Energy and Commerce and the Committee on Ways and Means.

### S. 1539 (HATCH ET AL.), HOME AND COMMUNITY-BASED SERVICES FOR THE ELDERLY AND THE DISABLED ACT OF 1983

Amends title XIX of the Public Health Service Act (health block grants) to establish a block grant program for home- and community-based services.Authorizes $20 million for fiscal year 1985 for program planning and implementation. For program services, authorizes $700 million for fiscal year 1986; $750 million for fiscal year 1987; and $800 million for fiscal year 1988. Allots funds to the States on the basis of the ratio of the total number of elderly individuals residing in a State to the total number of elderly individuals in all States.

Provides that grants awarded for fiscal year 1986 through fiscal year 1988 could be used by States for the following: (1) Activities to coordinate home- and community-based services provided to elderly and disabled persons by public and private institutions and organizations in order to eliminate duplication and to maximize the use of funds; (2) development of procedures and means to identify and assess elderly and disabled persons in need of community-based and home services; (3) identifying and assessing individuals in need of community-based services; and (4) the provision of specified home- and community-based services. Services which may be funded under the block grant include homemaker/home health aide services, physical, occupational, speech, or respiratory therapy, medical social services, medical supplies and appliances, drugs and biologicals (only if necessary for the individual to receive other services in such place of residence), respite care for 14 days or 336 hours in a calendar year, physician services, nursing services, adult day care, dietary services, and any other supportive services determined appropriate and necessary to prevent the need for placement of elderly and disabled individuals in acute or long-term care facilities.

Specifies various requirements for applications for allotments, descriptions of intended use of allotment, designation of a State agency to administer funds, public hearings, reports and audits, and direct funding for Indian tribes who apply and submit a plan meeting criteria prescribed by the Secretary.

The bill was introduced June 23, 1983, and included in S. 242, Employment Opportunities Act of 1983, reported by the Committee on Labor and Human Resources on July 14, 1983.

### S. 1540 (HATCH ET AL.)/H.R. 4268 (MOLINARI), COMMUNITY HOME CARE SERVICES ACT OF 1983

Amends the Public Health Service Act, the Older Americans Act, and title XIX of the Social Security Act (medicaid) to provide for greater coordination between these programs in the provision of home care services.

Allows a State to establish under its medicaid plan a program under which individuals needing long-term care may receive community-based home care services where medically appropriate and cost effective. The program is not required to be offered on a statewide basis. Persons who may participate are those individuals who are eligible for medicaid or who would be eligible if institutionalized, and those who would require institutional care but for the provision of community-based services. Any program established by the State shall assess the health care needs of each applicant, develop a plan of care for each eligible individual, and provide a case management system for each participating individual. The assessment, plan of care development, and case management functions are to be carried our by an assessment team consisting of a physician, registered nurse, and a social worker.

Home care services include the following items furnished to an individual under the care of a physician, or staff of a home health care entity, hospital, or long-term care facility certified to provide home care: Homemaker/home health aide services; physicial, occupational, speech, or respiratory therapy; medical social services; medical supplies; drugs and biologicals; respite care; physician services and nursing care; adult day care services; dietary services; and any other supportive services determined necessary and appropriate to prevent institutionalization, including patient and family training.

Provides that Federal funding to a State shall equal the Federal medical assistance percentage, plus 10 percentage points, of the total amount expended for home care services.

Amends title XVIII of the Social Security Act (medicare) to require that hospitals and skilled nuring facilities participating in medicare have in effect a procedure for the discharge planning of each patient who may be eligible for home care services under the State's medicaid plan established by the bill. The procedure must provide for informed freedom of choice on the part of the individual and the evaluation of the patient by an interdisciplinary team as to care required after discharge.

The Senate bill was introduced and referred to the Committee on Labor and Human Resources on June 23, and hearings were held on July 13, 1983. The House bill was introduced and referred to the Committee on Energy and Commerce and the Committee on Ways and Means on November 1, 1983.

### H.R. 3616 (WAXMAN ET AL.)

Amends title XVIII of the Social Security Act (medicare) to provide that with respect to home health services, nursing care and home health aide services may be provided on a daily basis (with one or more visits per day) for up to 90 days with monthly physician certification of the need for such services, and after the 90-day period, on a physician certification of exceptional circumstances. Also provides an additional 20 home health service visits beyond the time when the patient no longer qualifies for medicare home health visits on the basis of a need for skilled nursing care or physical or speech therapy.

The bill was introduced and referred to the Committee on Energy and Commerce and the Committee on Ways and Means on July 20, 1983.

### S. 1301 (HEINZ ET AL.)

Amends the Internal Revenue Code to allow a refundable income tax credit for expenses incurred in the care of a family member who is chronically ill and aged 75 or over, or who is diagnosed with Alzheimer's disease. Allows a tax credit of up to 30 percent of certain specified expenses for taxpayers with incomes of less than $50,000. Expenses are defined as payments for home health agency services, homemaker services, adult day care, and respite care services and certain health care equipment and supplies.

The bill was introduced on May 17, 1983, and referred to the Committee on Finance.

# Part IV

# HOUSING

## OVERVIEW

As the number of America's senior citizens grows, housing programs—and the public policy underlying these programs—take on increased significance. Furthermore, the fact that increasing numbers of frail elderly—those over 75—are aging in their longtime residences, raises issues that transcend housing policy alone. Questions of how to provide health care and supportive services in their homes must be examined, as well.

Overall Federal housing policy is shaped by the national value that all Americans are entitled to safe and decent shelter. To date, housing programs have focused almost exclusively on the provision of standard units of low- and moderate-income housing for eligible individuals and families. This approach has been inadequate in two major ways:

(1) The Federal Government is unwilling to treat housing assistance as an entitlement—the total of over 4 million assisted units projected to be available by 1985 is estimated to be enough for at best one-fourth of those eligible for assistance; and

(2) The focus on the provision of units of housing fails to address the needs of those currently assisted for supportive services and the need to promote shelter alternatives that incorporate such services.

The inadequacy of this approach is particularly acute for the 2.3 million older Americans who live in public housing and privately owned, federally assisted, low- and moderate-income projects. As they grow older in these projects—or "age in place"—the issue of frail, often immobile and/or mentally impaired elderly persons residing in inappropriately designed and located housing projects with few or no social supportive services, little or no supervision or security, and untrained management becomes one that Federal policymakers can no longer afford to ignore. To date, however, the two principal Federal agencies responsible for housing, the U.S. Department of Housing and Urban Development (HUD) and the Farmers Home Administration (FmHA), have expressed little interest in looking beyond the minimal responsibility to provide units of housing.

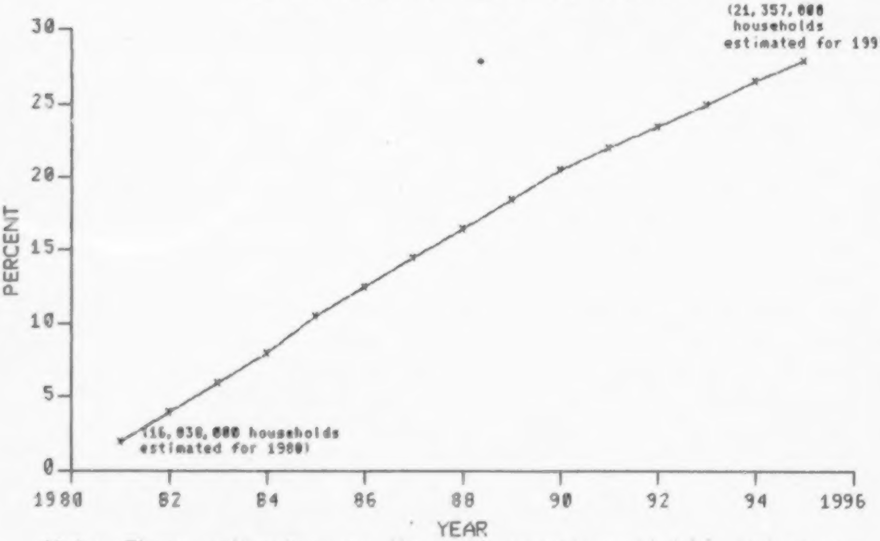
Federal housing policymakers need to reassess existing housing programs in light of the values driving health care and social services policy for the elderly. One commonly held goal is to enable the elderly to remain in their homes as long as possible. A corollary is that the frail elderly should be cared for in the least restrictive environment, both for quality of life considerations and for cost effectiveness. Increasing numbers of older persons are in need of in-home assistance or supportive living environments. Accommodating these needs will require greater cooperation between Federal housing, health, and human services agencies to promote the expansion of shelter alternatives.

## A. THE NATIONAL NEED

The "graying of America" is well-documented. The population 65 and over grew by 20.6 percent between 1960 and 1970, and by roughly 28 percent between 1970 and 1980. It is projected to grow by another 17 percent by 1990. Today, 26.8 million Americans are over 65.

The number of households headed by older persons is rising steadily. More than one-fifth of all U.S. households today—some 17.7 million—are headed by persons 62 or older. Nearly 10 percent are headed by persons over 75. From 1980 to 1995, the percentage of households headed by persons over 65 will increase 33 percent. Those headed by persons over 75 will jump 52 percent. In 1995, 21.4 million households will be headed by Americans over 65.

PROJECTED CUMULATIVE PERCENT INCREASES IN HOUSEHOLDS WITH HEAD 65 YEARS OR OLDER



Note: These estimates are the most recent available, but were completed prior to the 1980 Census

Source: U.S. Bureau of the Census, Current Population Reports, Series P-25, No. 805, Series C

The implications of these projections for housing in America, and for Federal housing policy in particular, are enormous. Indeed, roughly 2 million of the 3.2 million low-income elderly renters eligible for Federal housing assistance are currently not served by Federal programs.

Three out of every four elderly persons own their own homes, 80 percent of them, mortgage free. Yet a significant proportion of those elderly homeowners have low incomes, no other significant liquid assets, and need or receive some form of income assistance. These factors have contributed to the growing interest in home equity conversion proposals and in strategies for allowing the "overhoused" elderly homeowner to take more appropriate, more maintenance-free housing. This would have the beneficial side effect of freeing up the housing stock for potential first-time homebuyers frozen out of the market.

Rapidly escalating housing expenses have placed an enormous burden on the many older homeowners and tenants who live on fixed incomes. Increasing housing costs from taxes, utilities, home repair, and insurance, as well as rent hikes, condominium conversions, and housing displacement have resulted in a serious lack of affordable and safe shelter for a large number of older Americans. The cost of shelter is a particularly acute problem for renters because they pay a far larger proportion of their incomes for rent than other Americans. For example, recent data indicate that the median rent of an elderly woman living alone consumes almost 50 percent of her income. Some 2.3 million elderly households spend over 35 percent of their incomes on housing.

## B. THE FEDERAL RESPONSE

Over the years, the Federal Government has focused primarily on the needs of low-income renters. This is particularly true of the various subsidy programs. Federal Housing Administration (FHA) mortgage insurance programs and the housing benefits in the Tax Code, on the other hand, tend to favor homeowners and homebuilders.

*The major Federal housing programs:* Today, the principal Federal assistance programs are the section 8 existing housing program and public housing. The section 8 existing program provides assistance to households occupying existing dwellings. The public housing program and the new construction/substantial rehabilitation portion of section 8 were developed to increase the supply of affordable housing for low-income individuals eligible for Federal rental assistance. The latter program was repealed in the Housing Act of 1983. At the present time, roughly 50 percent of the 2.5 million units constructed through these two programs are occupied by older Americans. Even so, these two programs do not come to mind when the issue of Federal housing assistance for the elderly is raised; rather, policymakers as well as the public tend to focus on the section 202 program.

The section 202 direct loan program is designed specifically to construct low-income rental housing for elderly and handicapped Americans. But it provides less than 10 percent of the federally assisted units for the elderly. Approximately 101,000 new units are occupied by aged persons.

In addition to the elderly housing construction program, Congress in 1978 enacted the congregate housing services program. It authorized the Department of Housing and Urban Development (HUD) to award grants to public housing authorities and the nonprofit sponsors of section 202 projects to provide meals and supportive services to partially impaired elderly and handicapped persons.

The objective of the congregate program, which now has 62 projects serving more than 2,000 elderly, is to enable the frail elderly to remain in their own dwellings and to avoid unnecessary institutionalization. The demand for this and similarly designed programs that coordinate housing and supportive health care and housekeeping services in assisted housing as well as private homes is sure to increase enormously. In spite of this anticipated increase in demand, the concern over large Federal deficits makes any major new Federal initiatives in this area unlikely in the foreseeable future.

*The Housing Act of 1983 (Public Law 98-181):* In late 1983, Congress passed the first housing authorization bill in 3 years. Pressured by the administration and by continuing high Federal deficits, Congress eliminated authorizations for section 8 new construction/substantial rehabilitation. New construction of public housing units was restricted to 5,000 units. Authority to build new units would only be granted if a jurisdiction could prove that demand and an inadequate supply of usable, existing units made new construction the only reasonable alternative. Through the efforts of Senate Aging Committee Chairman John Heinz, and others who join him as members of the Senate Banking, Housing, and Urban Affairs Committee, the section 202 program remained at current levels of funding for 14,000 new units. Section 202 is the only program still authorized to use the section 8 new construction program. The congregate housing services program received funding to continue current projects and to initiate two rural projects.

Other features of the 1983 housing bill include the reinforcement of action taken in 1981 to limit eligibility for rental assistance to the neediest families—those at 50 percent of medium income—and to raise the rent contributions of those assisted from 25 to 30 percent of adjusted income. In a compromise forced by those opposed to the rent increase, deductions to adjusted income were raised for families with minor children and for the elderly.

Finally, the housing bill of 1983 reaffirms the administration's interest in the use and rehabilitation of existing housing. It also authorizes further experimentation with the administration's housing voucher proposal. The limited voucher program enacted in 1983 will be used in conjunction with multifamily projects assisted under a new rental rehabilitation and production program developed in part to replace the section 8 new construction program. This new two-part program probably will not get underway until late in 1984 and is not expected to provide a major source of housing for low-income elderly Americans. A portion of the 15,000 vouchers authorized for fiscal year 1974 will also be assigned to a new rural rental rehabilitation program to be administered by the Farmers Home Administration (FmHA) in the U.S. Department of Agriculture.

*Other Federal programs:* Farmers Home programs, specifically the section 515 loan program for the development of rural, multifamily, rental housing; the section 504 home repair loans and grants; and the section 521 rental assistance program, also annually provide significant assistance for elderly Americans living in rural areas of the country. These programs are frequently overlooked in analyses of Federal housing assistance for the elderly, even though figures from the 1980 census indicate that roughly one-third of all persons over 65 live in nonmetropolitan areas of the country.

Another HUD program of importance to older Americans is the community development block grant program (CDBG) which provides funds to local governments to assist low-income populations through housing rehabilitation, infrastructure repairs, and the provision of the social services. For instance, in 1981, more than $20 million was used to support local senior centers; and a significant portion of the CDBG funds was used for the rehabilitation and repair of rental units or private homes occupied by the elderly.

More burdensome perhaps, than repair costs, has been the dramatic rise in the cost of home energy. Recent increases in energy costs have been particularly devastating to the elderly and others with low incomes, who consume relatively less energy than other households but pay a larger portion of their disposable income for fuel. Since 1981, expenditures for home energy among low-income groups have increased, on average, by approximately 47 percent. The rise in energy costs in relation to income has been the impetus behind congressional enactment of the low-income energy assistance program and the weatherization assistance program.

The low-income energy assistance program is designed to provide funding to assist households in paying their fuel bills for either heating or cooling. The weatherization assistance program, on the other hand, is designed to improve the energy efficiency of homes through the use of insulation and other energy saving techniques to reduce consumption and thereby lessen the fuel bills of needy households. In response to the growing concerns about the effect of energy inflation on the poor and the high national unemployment rate, Congress provided increased funding for both programs during fiscal year 1983.

The difficulties faced by "asset-rich" but "income-poor" elderly homeowners continue to receive the special attention of the Aging Committee and of other Members of Congress. A proposal for a home equity conversion demonstration program was stricken from the Housing Act of 1983 at the last minute. The act does, however, require HUD to prepare a study of various home equity conversion concepts and to make recommendations to Congress. The act also includes provisions supporting the expansion of shared housing for the elderly. But there is a great deal more to be done in these areas.

## C. AGING COMMITTEE PLANS FOR 1984

The Special Committee on Aging will, in 1984, conduct a comprehensive review of the housing conditions of America's elderly, particularly those directly benefiting from Federal housing assistance programs and those benefiting indirectly from developer-oriented FHA mortgage insurance programs, State-run tax-exempt bond programs, and other tax expenditures embedded in the Internal Revenue Code. The underlying objective of the entire effort will be to establish and/or augment provisions of Federal law that enable the elderly to remain in their own homes and to avoid unnecessary or premature institutionalization in expensive health care facilities.

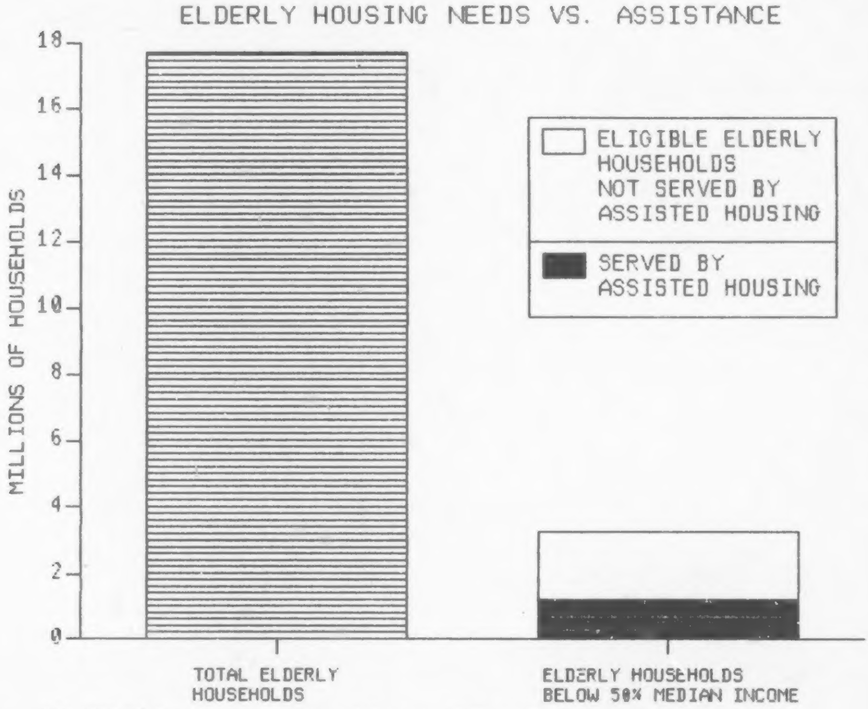
In effect, the committee will be interested in finding ways to implement the principles of the congregate housing program for all persons in need, rather than just those in a few federally assisted housing projects. The demand for similarly designed programs that coordinate housing, health care, and other supportive services will increase enormously in the next several decades.

Recent data from the National Center for Health Statistics indicate that the number of Americans experiencing limitations in the daily activities will rise from 31 million to 42 to 46 million shortly after the turn of the century. A proliferation of privately sponsored semi-independent living arrangements ranging from single room occupancy hotels (SRO's) and boarding houses to retirement and life care centers can be expected in response to this increase. The Federal Government will be asked to help communities to meet that demand and to incorporate more fully the values that underlie both national housing policy and health care and social services policy for the elderly.

# Chapter 14

# FEDERAL HOUSING PROGRAMS

Approximately 1.5 million units assisted under Federal housing subsidy programs are occupied by elderly households. Recent figures on the numbers of elderly households eligible for assistance (those below 50 percent of median income) indicate an additional 2 million families are not served by the Federal programs. A substantial number of these families may own their own homes, and although very poor, would not benefit from the subsidy programs designed for low-income renters.



Note: 250,000 Elderly households with over 50% median income also receive public housing assistance
SOURCE: Senate Appropriations Committee

In this chapter, the following programs will be discussed: public housing; section 8 new construction/substantial rehabilitation; section 8 existing housing certificates; vouchers; the new rental rehabilitation grant and rental housing development grant programs; section 202; congregate housing; and Federal Housing Administration (FHA) mortgage insurance programs. A second section of the chapter will discuss briefly the community development block grant program; mortgage revenue bonds; and housing assistance programs in the Farmers Home Administration (FmHA).

SUMMARY OF HUD HOUSING UNITS FOR THE ELDERLY

[All figures represent number of projects/units currently insured by FHA unless otherwise noted, as of Oct. 31, 1982]

| Section No.: Program: Status | Projects | Units | Mortgage amount | Number of elderly units | Percent of units |
|---|---|---|---|---|---|
| CONSTRUCTION PROGRAMS | | | | | |
| Title II: Low-income public housing: Active | 15,110 | 1,486,344 | (6) | [4] [5] 638,375 | 42.9 |
| 202: Direct loans for housing for elderly and handicapped: | | | | | |
| Inactive | +830 | 45,275 | $74,580,000 | 45,275 | 100 |
| Active [3] | 1,458 | 106,386 | 3,967,755,076 | 95,340 | 89.6 |
| 231: Mortgage insurance for housing elderly: Active | 504 | 66,228 | 1,172,667,185 | 66,228 | 100 |
| 221(d)(3): Multifamily rental: Active | 3,591 | 472,514 | 5,949,219,649 | 23,892 | 5.1 |
| 221(d)(4): Housing for low and moderate-income families: Active | 6,289 | 675,128 | 18,075,741,333 | 92,110 | 13.6 |
| 235: Homeownership: Inactive | [3] 255,435 | (6) | 4,596,861,864 | (6) | (6) |
| 235: rev.: Assistance for low and moderate-income families: Active | 80,923 | (6) | 2,905,475,104 | (6) | (6) |
| 207: Multifamily rental housing: Active | 1,890 | 243,308 | 3,645,929,754 | 3,376 | 1.4 |
| 236: Rental and co-op assistance for low and moderate-income families: Inactive | 4,055 | 434,308 | 7,538,768,937 | 55,279 | 12.7 |
| 202/236: 202/236 conversions: Inactive | 181 | 28,059 | 480,098,460 | 28,059 | 100 |
| 232: Nursing home and intermediate care facilities: Active | 1,367 | [7] 162,062 | 1,991,577,976 | [7] 162,062 | 100 |
| NONCONSTRUCTION PROGRAMS | | | | | |
| Net reservations | 26,371 | 1,873,827 | (6) | 782,774 | 41.6 |
| 8: Low-income rental assistance | | | | | |
| Existing: Active | 13,969 | 1,071,792 | (6) | 305,073 | 28.5 |
| New construction: [1] Active | 10,477 | 671,617 | (6) | 425,189 | 63.3 |
| Substantial rehabilitation: [1] Active | 1,925 | 130,418 | (6) | 52,512 | 40.3 |
| 312: Rehabilitation loans: Active [2] | 86,004 | (6) | (6) | 6,243 | 7.25 |
| 23: Low rent leased housing: Inactive | (6) | 163,267 | (6) | +54,000 | [8] 35+ |

[1] Figures do not include section 8 commitments attached to section 202/8 fund reservations.

[2] Figures represent loan commitments only.

[3] Figures represent number of mortgages.

[4] Figure include approximately 250,000 units not specifically designated but used by elderly.

[5] Does not include section 8 units owned by public housing agencies.

[6] Not available.

[7] Beds.

[8] Approximate.

## A. THE MAJOR FEDERAL HOUSING PROGRAMS FOR THE ELDERLY IN THE DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT (HUD)

### 1. Public Housing

The low-rent public housing program is the oldest of those Federal programs providing housing for the elderly. It was established by the United States Housing Act of 1937. Over 42 percent of the Nation's more than 1.5 million public housing units are occupied by older Americans. It is a federally financed program which is operated by locally established, nonprofit public housing agencies (PHA's). Each agency usually owns its projects. By law, the PHA's can acquire or lease any real property appropriate for low-income housing. They also are authorized to issue notes and bonds to finance the acquisition, construction, and improvement of projects.

Federal assistance to the public housing projects is in the form of annual contributions that are used to pay the PHA's debt service. Originally this was the only form of Federal public housing assistance. It was assumed that tenant rents, set at amounts no higher than 25 percent of a tenant's net income (now raised to 30 percent), would cover project operating costs for such items as management, maintenance, and utilities. Over the past few years, tenant rents have not kept pace with increased operating expenses. Recent changes requiring greater targeting of benefits to the very low income (50 percent of area median rather than 80 percent) also decrease rental revenues for the public housing authorities. As a result, Congress has provided additional assistance to the projects to cover these expenses. Annual operating subsidies total $1.3 billion in fiscal year 1984.

A large percentage of new construction of public housing over the last 10 years has been for the elderly. The relative lack of management problems and local opposition to family units make elderly projects more popular. Yet, even with this preference for the construction of units for the elderly, in many communities, there is a long waiting list for admission to projects serving the elderly. Such lists can be expected to increase as the demand for elderly rental housing continues to increase in many parts of the Nation.

Since 1971, PHA's have had the authority to use Federal funds for the provision of dining facilities and equipment in public housing projects. (No subsidy was to be provided to cover the cost of meals and other services.) To date, there has been little development of these "congregate" facilities. A study on long-term care released by the Department of Health and Human Services in late 1981 cited a variety of reasons for this including: Local housing agencies have had little experience in managing the necessary services; there has been little Federal encouragement and support; and there is no assurance of funds to pay for the services on an ongoing basis. Most services have been provided by local services agencies funded by the Older Americans Act, medicaid, and the title XX Social Services Act.

Consistent with past trends, the demand for operating subsidies for PHA's will continue to increase. However, in fiscal year 1985, it is anticipated that stabilization of utility costs, better management, and stricter accounting with respect to vacant units will slow the pace of recent increases in the subsidies.

Other major funding commitments for public housing in fiscal year 1984 are: (1) The authorization of 5,000 units of new construction in jurisdictions with insufficient existing rental units; and (2) modernization funds. $1.6 billion is appropriated in fiscal year 1984 for the comprehensive improvement and assistance program (CIAP), the modernization program. In an attempt to resolve continuing controversy over the level of CIAP funding between Congress and the administration, $4 million was appropriated for a comprehensive 2-year study of the modernization program. The study will determine the national level of need to bring vacant, rehabitable public housing units up to decent and safe standards.

In other action in the Housing Act of 1983, Congress precluded the administration from initiating any fundamental structural changes in the operating subsidy and modernization programs in 1984. If the administration wants to make changes in 1985, it has agreed to do so through legislative proposals rather than via administrative or regulatory action. In taking this action, Senator Heinz and other congressional leaders in housing policy intended to give local public housing authorities time to improve management practices with a stable set of Federal statutes and regulations.

### 2. SECTION 8

The concern over the Federal deficit has forced the Federal Government to reassess the cost effectiveness of many social programs, including the new housing construction programs. Neither section 8 nor section 202 was designed originally to provide any form of direct subsidy to project sponsors in meeting their costs of construction and financing. Both were structured to stimulate construction by guaranteeing that low-income occupants would be subsidized through rental assistance programs, thereby assuring occupancy (and rental income) for the developed units.

It became evident in 1981 that high interest rates in both the public and private financing markets were threatening to halt section 8 and section 202 assisted housing production programs unless some sort of development assistance was made available. By the end of 1982, limited additional assistance had been provided to section 8 and section 202 sponsors in the forms of finance adjustment factors (FAF's) and mortgage revenue bonds as further subsidies to the direct low-interest loans and the rental assistance for occupants. Finally, in the House Act of 1983, the section 8 new construction program was repealed.

The section 8 program was created in 1974 to provide subsidized housing to households with incomes too low to obtain decent housing in the private market. Under the program, HUD entered into assistance contracts with owners of existing housing or developers of new or substantially rehabilitated housing for a specified number of units to be leased by households meeting Federal eligibility standards. Payments made to owners and developers under assistance contracts were used to make up the difference between what the rental household can afford to pay for rent, and what HUD has determined to be the "fair market rent" for the dwelling. At the end of October 1982, it was estimated by HUD that approximately 783,000 units, or 42 percent of the more than 1.9 million total section 8 units, were occupied by older persons. Over 425,000, or 63 percent, of the newly constructed units were occupied by the elderly.

*Section 8 existing housing:* While the production component of the section 8 program has been viewed as unsuccessful, the existing housing component of the section 8 program has generally been alluded to as a successful form of assistance.

The administration's emphasis on the section 8 existing housing program is based not only on cost considerations but also on the administration's belief that there is an adequate supply of low- and moderate-income rental housing in most areas of the country. The administration has contended that the need for housing assistance in America can be met best by providing section 8 certificates or, preferably, vouchers to eligible families for use in existing rental housing.

*Tenant rent contributions:* Prior to fiscal year 1982, families assisted under section 8 were required to contribute not less than 15 percent and not more than 25 percent of their net incomes toward rent. However, the Omnibus Budget Reconciliation Act of 1981 increased the tenant share from not more than 25 percent to not more than 30 percent of net income. For those renters already living in section 8 units, the adjustment was to be made over a 5-year period, with annual percentage increases in rent limited to 10 percent or less. Only new tenants were to be immediately subject to the full effect of the change.

The 1981 act also reduced the income eligibility limit to 50 percent of the median income in the local area from the previous limit of 80 percent. It was assumed that this provision would better match low-income housing programs with those who are most in need of assistance. This change was to apply to new tenants only; the continued eligibility of current tenants with incomes above 50 percent of median income was unchallenged. HUD regulations implementing these changes in the law were promulgated in 1982.

During consideration of the Housing Act of 1983, efforts to restore the 25 percent rent-income ratio for assisted households were unsuccessful. A compromise kept the ratio at 30 percent of adjusted income, while increasing the permitted deduction from income before calculating the rent to $480 for each minor dependent or full-time student, and $400 for elderly households.

In an effort to further reduce Federal spending for assisted housing programs, the administration proposed another initiative to increase tenants' rent contributions for fiscal year 1984. If enacted, this initiative would have required that the cash value of food stamps be counted as cash income in calculating the rent contributions. Elderly households and those headed by females with children would be the two groups most affected by such a proposal. A 1981 study by the Department of Agriculture found that these two groups, comprising over 85 percent of all households who participate in both food stamp and housing programs, would have forced rent increases. Of elderly households, those most affected would have been women living alone. The departmental study further reported that over 80 percent of the households in these groups had annual incomes below $5,000, and almost 50 percent had incomes below $3,000.

On April 23, 1982, the Senate Special Committee on Aging held a hearing to examine the impact of various HUD legislative proposals on older Americans. Much of the testimony focused on the administration's voucher proposal, but the committee also heard testimony from witnesses on the administration's original proposal to count food stamps as income in fiscal year 1983. The consensus was that the proposal would have a disproportionately higher adverse effect on the poorest of the low-income assisted housing recipients.

HUD was asked about regulations under consideration to cap the amount of deductions for unreimbursed medical expenses at $300 per year in the calculation of tenant rent payments. The administration stated that the purpose of such a regulation would be to simplify the current, complex system used for determining medical deductions on an individual basis. The $300 figure was one HUD determined to be above the average medical allowance now taken by the average elderly section 8 recipient.

Witnesses from the National Low-Income Housing Coalition and the New England Elderly Housing Association said, that while HUD's determination of an average medical deduction might be correct, it would be unfair to handle these deductions in this manner. Unreimbursable medical expenses are a basic cost of living that can vary substantially from person to person, the committee was told. Low-income elderly persons with the same income but greater medical needs would be forced to pay higher rents than healthier recipients if an average medical deduction were implemented, resulting in a lower standard of living for the sickest of the poor. Changes in current medical expense deduction regulations were never officially proposed by the administration in 1982. Efforts to change the current deduction were made again in early 1983, but met with strong opposition in both the Senate and House authorizing committees. The Housing Act of 1983 continues the current law on medical deductions for the elderly.

### 3. VOUCHERS

The Housing Act of 1983 continued section 8 existing certificates and established as section 8(c) an experimental voucher program. Use of the 15,000 vouchers authorized by the act is limited to HUD's new rental rehabilitation program and the FmHA rental preservation grant program.

Under the section 8 existing housing program, HUD pays the difference between 30 percent of an assisted housing tenant's income and the fair market rent standard for the jurisdiction. Under the administration's voucher proposal, also referred to originally as the modified section 8 existing housing certificate, HUD's contribution will be based on the difference between an established rent payment standard for each market and 30 percent of a new tenant's rent. The rent standard will be set at the 45th percentile of the distribution of all rents for all rented units of standard quality, including new units. As with current law, tenant eligibility would be based on an income standard of 50 percent of area median income.

The vouchering program will allow tenants to pay more or less than 30 percent of their income for rent. However, HUD's contribution would still be based on a 30-percent-of-income contribution. Thus if a tenant could find a unit which is cheaper than HUD's rent standard, that tenant would be able to keep some of the subsidy for other uses. Conversely, if a tenant rents a unit which is more costly than the rent standard HUD uses, that tenant would have to contribute more than 30 percent of income to make up the rent payment.

At the April 23, 1982, hearing held by the Aging Committee, administration officials from HUD, Dr. Ray Struyk of the Urban Institute, and other witnesses knowledgable about elderly housing policies and problems, testified at length about the vouchering proposal.

While Dr. Struyk agreed with the administration about the need to place greater emphasis on the use of existing housing stock to house older Americans, he felt the administration's voucher proposal was flawed. According to Struyk, the amount originally proposed to be made available to recipients on a per voucher basis would be insufficient, and, because of regional differences in housing and other living costs, would result in a disproportionate distribution of benefits among the poor. The major findings of Struyk's study of Federal housing programs for the elderly were as follows:

—There are about 2.3 million elderly households spending over 35 percent of their incomes on housing. Forty-one percent of elderly renters with incomes below the poverty line spend over 45 percent of their income for rent.

—Mobility rates of the elderly are only about one-third of those of the nonelderly, with little variation among renters by income level or household type. These low mobility rates may be found to inhibit participation in housing assistance programs, such as the voucher program, when relocation is necessary to quality for assistance.

—The elderly constituted about 39 percent of all assisted through HUD programs. Section 202 and section 8 new construction assisted the elderly at the highest level. Overall, about 72 percent of the elderly in subsidized housing are being assisted through new construction programs.

—Thirty-six percent of the elderly assisted housing program participants receive food stamps.

—Under the vouchering proposal, elderly couples would receive payments at lower rates than elderly single persons. Program participation would probably be influenced by the size of the subsidy. Because single persons have lower incomes than couples, a higher participation rate could be expected from them.

The Senate Aging Committee will monitor closely the implementation of the voucher experiment in fiscal year 1984. However, given a probable preference for large families with children in the new rental rehabilitation program, the experiment is not likely to have a great impact on the elderly.

### 4. THE NEW RENTAL REHABILITATION AND DEVELOPMENT PROGRAMS

New rental rehabilitation and production programs were enacted in the Housing Act of 1983. They feature Federal commitments of just 5 years (much shorter than the 15- or 20-year commitments under section 8); greater requirements for local public and private sector investments in the projects; stricter limits on Federal per unit costs; and greater demonstration of rental housing need by local authorities. HUD regulations for these new programs are to be submitted to Congress early in 1984.

The $150 million rental rehabilitation program will be formula driven and will allocate funds directly to entitlement cities and urban counties. States will run the program for smaller communities. The program is designed to benefit low- and moderate-income families, with some priority given to projects assisting nonelderly, large families. HUD plans to assign new commitments for 10,000 vouchers and 20,000 section 8 existing housing certificates to the program in fiscal year 1984.

The $200 million rental development program will be run on a competitive grant basis and targeted to only the most distressed cities and counties. Again, HUD is likely to give some priority to projects with units for large families. Implementation of this program is likely to be delayed considerably by controversy over eligibility, per unit cost limits, tenant income mixes, and other unresolved issues.

A total of $615 million was authorized in the Housing Act of 1983 for these two programs for fiscal year 1984 and fiscal year 1985. These are very modest programs, compared to the costs of the section 8 new construction/substantial rehabilitation programs which they are designed to replace. The latter, for instance, were allocated more than $10 billion in new budget authority in fiscal year 1981.

### 5. SECTION 202

The section 202 program is the primary Federal financing vehicle for constructing subsized rental housing for elderly persons. Under the section 202 program, the Federal Government makes direct loans to private, nonprofit sponsors for use in developing section 8 housing designed specifically to meet the needs of the low-income elderly and the handicapped. Since the program's authorization in 1959, over 101,000 units have been constructed.

The original section 202 program operated from 1959 to 1969, when it was phased out in favor of other programs. During this 10-year period, the program provided construction financing and 50-year permanent loans at 3 percent interest to nonprofit and limited dividend sponsors of housing for low- and moderate-income elderly and handicapped persons. Approximately 45,000 units were constructed.

Under the revised section 202 program, authorized in 1974, loans to sponsors were made at a rate based on the average interest rate of all interest-bearing obligations of the United States forming a part of the public debt, plus an amount to cover administrative costs. In 1981, the Treasury borrowing rate began to rise and prospective sponsors feared that financing would become too expensive for them to undertake construction. In 1982, the Senate Committee on Banking, Housing, and Urban Affairs, agreed that HUD should keep the interest rate at 9¼ percent, and in December of that year, HUD concurred that the 1983 interest rate on these loans would remain at 9¼ percent. The 9¼ percent cap was extended for another year in this fiscal year 1984 HUD appropriations bill.

The original section 202 program was successful. Only one project was foreclosed in a 10-year period. The program served basically middle-income rather than low-income elderly. The public housing programs served most of the low-income elderly during this time. Since the revised program is used in conjunction with the section 8 program (HUD's major vehicle for the provision of housing to low-income households), it serves a wider income range of elderly families.

Under the revised section 202 program, funds are allocated on a geographic basis for metropolitan and nonmetropolitan areas among the 10 HUD regions, taking into account the number of elderly households within each region, those households lacking some or all plumbing facilities, and those with incomes below regionally adjusted poverty levels. In 1981, there were approximately 4.5 million elderly rental households representing about 30 percent of all elderly headed households in the United States.

The Department of Housing and Urban Development—Independent Agencies Appropriation Act of 1984 (Public Law 98-45) appropriated $666.4 million of direct loan obligations to be made under the section 202 program. This amount is intended to provide funding for the construction of approximately 14,000 section 202 units. Applications from nonprofit sponsors for such loans are due in March 1984. HUD may require a sponsor to deposit up to $10,000 in an escrow account to insure his commitment and responsibility.

The Housing Act of 1983 (Public Law 98-181) includes several provisions for the section 202 program. The act sets the maximum loan interest rate at 9¼ percent for fiscal year 1984; authorizes $666.4 million to be used for lending authority; and sets aside $50 million for the rental needs of the handicapped.

Besides these authorized loan limitations, the bill also added several cost limitations to the section 202 programs. The Secretary of HUD may require of a sponsor that 25 percent of the units be efficiencies, if such units are appropriate for the need in the area. Also, HUD is to consider what amenities are needed by residents of such projects and to adjust the cost limitations of these amenities once a year to reflect changes in construction costs. While HUD is to cut costs as much as possible, any sponsor may voluntarily provide funds for special features, amenities, or designs in a project as long as these features are not considered in determining the amount of Federal subsidy or the rent contribution of tenants.

After considerable discussion as to who should choose contractors for the construction of section 202 projects, HUD or the project's sponsors, it was decided that the sponsor or borrower could hire the contractor under the following conditions: (1) If the development cost of the project is less than $2 million; (2) if rents will be less than 110 percent of fair market rents in the area; or (3) if the sponsor is a labor organization. Otherwise, HUD will determine the contractor of the project by means of competitive bidding. It is expected that fewer than 20 percent of section 202 projects will have to use the competitive bidding procedures.

There was also much discussion in both the House and Senate during 1983 concerning the prepayment of loans for financing section 202 projects. The Housing and Urban-Rural Recovery Act made it clear that HUD was not to approve the prepayment of any loan unless it was insured that the project would continue to operate until the original maturity date of the loan, in a manner which would provide rental housing for present and future tenants under the terms required in the original loan agreement.

Many elderly tenants of section 202 and other subsidized housing units have been concerned about the regulations against keeping pets while living in subsidized housing. The necessity of giving away pets in order to move into federally assisted housing has kept some elderly from applying for decent, afforadable housing. After several bills had been introduced in both the House and Senate, Congress voted to permit reasonable pet ownership in subsidized housing projects for the elderly. In the Housing and Urban-Rural Recovery Act of 1983, HUD was ordered to establish guidelines for pet ownership to be followed by owners, managers, and tenants of a project. As long as a pet meets size limitations and tenants having pets meet the financial requirements and standards of pet care, they cannot be refused admittance to a federally assisted project. However, should a pet become a health or safety threat to other tenants, it may be required to be removed.

Senator Heinz and others introduced legislation to amend current law to revise and expand the section 202 program on July 20, 1983. The bill (S. 1648), would consolidate current assistance to meet elderly housing needs within a single, more efficient program. Similar legislation (H.R. 2435) was introduced by Congressman Lundine in the House of Representatives. Major portions of Mr. Lundine's were included in the housing authorization bill, H.R. 1, by the House Banking, Finance, and Urban Affairs Committee. However, the provisions were dropped during House-Senate negotiations on the 1983 housing bill until further study had been made. Under the proposal, beginning in fiscal year 1985, 18,000 units would be authorized each year under the nonprofit sponsorship component of the revised 202 program. An additional 18,000 units would also be available under a new supplemental program involving partial funding and administrative support from the State housing agencies.

A key difference from the current program in this proposal is the revised financing and subsidy mechanism for the section 202 program. Instead of interest-bearing, amortized loans, and section 8 subsidies, assistance would be provided to section 202 projects in the form of deferred-payment advances and annual operating subsidies. The advances would be repayable after 20 years, with the Secretary of HUD authorized to forgive all or part of the advance if a project continues to serve a similar group of elderly or handicapped tenants during a second 20-year period. The 26 organizations of the Ad Hoc Coalition for Housing for the Elderly and the Council of State Housing Agencies support S. 1698. The bill was referred to the Senate Banking, Housing, and Urban Affairs Committee.

To help assess the present section 202 program, the Senate Aging Committee began a national survey of all 202 project sponsors/administrators in August 1983. The purpose of the survey was to obtain an up-to-date "picture" of the current program. Sponsors were asked to respond to questions regarding demographics, waiting lists, operating costs, meal programs, and services offered by the projects. An analysis of the results of the survey is due in early 1984.

### 6. CONGREGATE HOUSING SERVICES

The Congregate Housing Services Act of 1978 authorized HUD to award grants to public housing authorities and section 202 housing sponsors to provide nutritional meals and supportive services for tenants in their projects. The program was set up to be a demonstration program, with $20 million appropriated to be spent over a 5-year period, after which HUD is to give an evaluation and report to Congress. The program's chief function is to help the elderly remain in the rented dwellings as they age, rather than be institutionalized. It has been demonstrated that providing low-cost meals and other support services in a residential setting can prevent premature institutionalization and unnecessary hospital stays.

At the end of 1983, 62 congregate projects serving over 2,000 elderly persons were in operation. Since the program was set up as a demonstration program, Congress felt that no new appropriations should be made for the program in the budget for fiscal year 1982 and fiscal year 1983. However, as fiscal year 1983 progressed, Congress recognized a need for the continued funding of congregate projects which were already in existence. The fiscal year 1983 HUD and Independent Agencies Appropriation Act provided $3.5 million for this purpose, as well as additional $500,000 for new projects in rural areas. In the Housing Act of 1983, Congress authorized $4 million for the congregate services program, and asked the Secretary of HUD to submit a report by March 1984, which evaluates and makes recommendations for enlarging or making the program permanent.

No data exists from which to predict the number of elderly people who need or prefer congregate housing facilities. But witnesses at hearings before the Senate Special Committee on Aging estimated between 200,000 and 300,000 of the 27 million persons over age 65 and not living in institutions or nursing homes would choose to relocate to congregate housing if facilities were available.

### 7. Federal Housing Administration (FHA) Mortgage Insurance Programs

The FHA operates about 40 programs that provide insurance for home and multifamily project mortgages, and for property-improvement and mobile-home loans. The principal one is FHA's basic single-family, unsubsidized home mortgage insurance program (section 203(b)). Of more significance to elderly households are: Sections 207, 221(d)(3), and 221(d)(4), which provide mortgage insurance for multifamily rental projects; section 231, which is specifically for elderly rental projects; and section 232 which insures mortgages for nursing homes and intermediate care facilities. FHA mortgage insurance is also available for hospital construction under section 242.

HUD recently issued a new regulation permitting FHA mortgage insurance for retirement service centers under the section 221(d)(4) program. The Department has received an increasing number of requests from prospective developers for an insurance program which covers the gap between the totally independent living arrangement of noncongregate housing for the elderly and the health-care-oriented nursing home. Facilities under this new program would be limited to market rate elderly tenants. While direct medical care would not be provided, a package of meals, services, and amenities exceeding any normally submitted under the section 221(d)(4) program most likely would be included.

In the past, several of the FHA mortgage insurance programs for multifamily rental development could be used in conjunction with section 8 new construction and substantial rehabilitation subsidies and/or tax exempt bonds. With the cancellation of the section 8 program, and the temporary failure to extend the mortgage revenue bond program, FHA mortgage insurance by itself provides insufficient financial incentive for the development of low- and moderate-income family projects. The FHA insurance program will continue to be active for those developing higher income rental projects.

## B. OTHER FEDERAL PROGRAMS AFFECTING ELDERLY HOUSING

Several direct and indirect housing subsidy programs will be discussed briefly in this section. These programs—community development block grants, Farmers Home Administration (FmHA) programs, and housing-related tax provisions—are generally not included when the issue of Federal housing assistance for the elderly is considered.

### 1. Community Development Programs in the U.S. Department of Housing and Urban Development (HUD)

The community development block grant (CDBG) program provides $3.5 billion annually to communities to conduct a wide range of development activities. Approximately $2.5 billion of this sum goes to 732 cities and urban counties by entitlement, with individual amounts determined by formula. The balance, approximately $1 billion administered by the States, goes to small cities under 50,000 population.

The program's primary objective is the development of viable urban communities by providing decent housing, and expanding economic opportunities. Block grant funds must be expended to help low- and moderate-income households, to eliminate slums and blight, or to meet other urgent community development needs.

Elderly persons benefit directly and indirectly from a variety of CDBG-funded projects. However, because of the decentralized nature of the CDBG program, and because local communities are not required to report program beneficiaries by age, it is impossible to estimate what proportion of CDBG funds directly addresses the needs and problems of the elderly. Available information does show that slightly more than $16 million of CDBG entitlement program funds were budgeted specifically for assistance to senior centers.

A significant portion of local funding for housing rehabilitation activities, which in itself represents approximately 35 percent of all CDBG entitlement spending, benefits the elderly homeowner. For example, many communities use CDBG funds to make home improvement grants, write down the interest rates of conventional home improvement loans, forgive repayment of home improvement loans, and provide weatherization services for elderly owners and renters. These home repair and weatherization programs contribute significantly to the ability of poor, elderly families to stay in their homes. In addition, significant amounts of CDBG entitlement spending for neighborhood improvements, public services, public housing rehabilitation, and other public works indirectly benefit the elderly.

As in the CDBG entitlement program, elderly persons benefit directly and indirectly from a variety of small city CDBG-funded projects. While the exact level of benefit to the elderly cannot be determined, it is known that at least 18 senior citizen center projects received an average of more than $50,000 in CDBG assistance in fiscal year 1982. States also awarded substantial sums of CDBG funds for other activities that provided some benefit to the elderly, most notably housing rehabilitation.

Cities and urban counties which meet minimum standards of physical and economic distress are eligible for urban development action grants (UDAG's). Since the inception of the program in 1978, UDAG awards have helped communities develop downtown and suburban shopping areas, community centers, and public facilities that have indirectly benefited the elderly. Projects that have directly benefited elderly persons and households include the expansion of urban health centers and the development of community care homes.

Finally, the section 312 rehabilitation loan program, as established by the Housing Act of 1964, provides direct loans to eligible property owners to assist them in rehabilitating single-family and multifamily residential properties and neighborhood-scale nonresidential properties. The program has recently operated in conjunction with and in support of other community development programs, primarily the community development block grant (CDBG) and the urban homesteading programs. Although no data are available on the ages of the recipients of these loans, which have been primarily for single-family homes, in recent years, approximately one-sixth of section 312 loans were made to elderly homeowners.

### 2. FARMERS HOME ADMINISTRATION (FMHA) PROGRAMS FOR THE ELDERLY

Farmers Home programs provide significant benefits to older Americans, one-third of whom live in nonmetropolitan parts of the country. Indeed, several of the programs were designed specifically to aid the low-income elderly.

The section 504 home repair loan and grant program provides special benefits to low-income elderly homeowners by offering loans at 1 percent interest rates, $12.5 million in outright grants of up to $5,000, and combined low-interest loans and grants of up to $7,500. Low-interest loans also are made to low-income elderly homebuyers under the section 502 programs.

Elderly low-income renters may qualify for FmHA's section 521 rental assistance program, which is comparable to section 8. Originally, the section 515 program was exclusively for the development of rental housing for low- and moderate-income elderly families. In fiscal year 1983, 25 percent of the loans were for the construction of elderly projects.

The FmHA has authority under the section 515 rural rental housing program to build congregate housing for the elderly and handicapped. Developers who apply to FmHA for loans to build congregate facilities coordinate with social service agencies to obtain support for the provision of supportive services.

A joint congregate demonstration program was formalized in a memorandum of understanding between FmHA and the Administration on Aging (AoA) in 1979. FmHA allocated approximatly $10 million for the construction of 10 specifically designed congregate projects (30 to 40 units each). AoA provided 3-year demonstration funds ($85,000 annually) for services in each facility. The 10 demonstration projects are completed and fully occupied. The AoA has provided a no-cost extension of this demonstration for fiscal year 1984.

### 3. Housing Related Tax Provisions

The principal tax provisions promoting homeownership and the production of housing in this country include: Homeownership tax subsidies; rental housing investment subsidies; and tax-exempt mortgage revenue bonds. Of principal interest to elderly Americans are: The one-time exemption from taxes of up to $125,000 in capital gains for those over 55; and the multifamily rental production incentives provided in the Tax Code and through mortgate revenue bonds.

Given current high interest rates, there would be very little construction of multifamily rental housing without tax provisions such as accelerated depreciation; amortization of construction-period property tax and interest expenses; low-income rental housing rehabilitation and historic preservation tax credits; and the sale of tax-exempt bonds. Even so, these incentives tend to lead to the production of housing for renters in the moderate and upper income brackets, rather than for the poor. Low-income projects are more risky, are less profitable, and attract fewer investors. For this reason, tax-exempt bonds for multifamily mortgages have been statutorily limited to projects with at least 20 percent of their units occupied by low-income renters. For similar reasons, several of these rental housing investment tax subsidies and the mortgage revenue bond program have come under increasing attack from Treasury officials and Members of Congress concerned about untargeted Federal tax expenditure programs.

The tax-exempt bond program has led to the establishment of State housing finance agencies, some of which are engaging in innovative housing programs for the elderly. There are also many State and local tax provisions which serve as incentives for housing rehabilitation and rental housing investment.

# Chapter 15

# PRIVATE HOUSING OPTIONS FOR OLDER AMERICANS

## A. INNOVATIVE HOUSING ARRANGEMENTS

### 1. Home Equity Conversion Plans

Homes of older Americans are their most commonly held and most valuable asset. Recent statistics indicate that of the three out of every four elderly persons who own their own homes, 80 percent do not have a mortgage. Equally as significant, older homeowners are likely to have relatively low incomes. For example, 6 out of every 10 elderly single homeowners have incomes of $5,000 or less.

A great deal of attention has been given in recent years to financial arrangements which would permit aged homeowners to convert part of their equity into cash, without having to leave their dwellings. These home equity conversion plans (HECP's) offer a choice to elderly persons facing necessity-heavy budgets that have grown proportionately faster than their incomes. They could also provide funds to allow older persons to pay for needed support services, home maintenance, and other needs. Before HECP's, the only source of equity borrowing available to older Americans was through the traditional financial institutions at high rates and short terms.

There are two distinct types of conversion plans—debt and equity—that a variety of models are based on. Debt plans allow an older homeowner to borrow against home equity with no repayment of principal or interest due until the end of a specified term of years, or until the borrower sells the home or dies. These plans can provide a single lump-sum payout to the borrower, a stream of monthly payouts for a given term or—with the addition of a deferred life annuity—guaranteed monthly payouts for life. They are often referred to as "reverse" mortgages or reverse annuity mortgages (RAM's).

Property tax deferral programs, popular in many States, are a form of debt plan in which older homeowners postpone paying their taxes until they sell their homes or die. In State-initiated deferral programs, the State pays taxes to the local government for the homeowner. These payments accrue with interest as a loan from the State to the homeowner, secured by equity in the home. Upon death or prior sale of the home, the total loan is repaid to the State from the proceeds of the sale or the estate.

Equity plans involve sale of the home to an investor, who immediately leases it back to the seller. Land contract payments to the seller exceed rent payments to the buyer, so the older person receives extra cash each month. In addition, the buyer pays for taxes, insurance, and maintenance. A deferred annuity or other investment purchased with the downpayment can provide income beyond the land contract term. These plans are also referred to as "sale/leasebacks."

The basic theoretical forms of HECP's have been developed for several years. In general, however, workable instruments have yet to become widely available to the public. Private sector HECP's have been sporadic and short-lived. One reason for the lack of substantial interest is that the combination of financial benefits and risks associated with the plans has not been sufficiently attractive to lenders or borrowers.

Volatile interest rates have made plan development even more difficult. Yet progress has been made. Two pilot programs launched in 1981 were in full operation in 1983. The San Francisco Development Fund's reverse annuity mortgage program is a comprehensive system for delivering reverse mortgages and sale/leasebacks to older homeowners. Buffalo's Home Equity Living Plan (HELP), Inc., offers elderly homeowners immediate property rehabilitation as needed, a lifetime maintenance contract, payment of property taxes for life, and a monthly cash payment for life. In exchange, the homeowner agrees to relinquish title at death.

At the end of 1983, a new home equity conversion plan model emerged from a private corporation, American Homestead, Inc., (AHI), a licensed mortgage bank in New Jersey. The Century Plan is the first long-term reverse mortgage. The plan has been designed to attract the interest of the private financial market. Under the plan, older homeowners would receive monthly checks ranging from $100 to $500 as an income supplement until the homeowners asked to have them stopped or until the owners move, sell their property, or die. When the payments end, the homeowners or their heirs would owe the dollar amount of the monthly checks; deferred interest computed at a fixed rate slightly below what was prevailing in the mortgage market at the time the original payment contract was signed; and a percentage of the increase in the resale value of the house since the date of the original contract. All loans to property owners would be secured by first mortgages against their homes.

By "pooling" the mortgages into packages of 1,000 loans apiece, American Homestead hopes to cut the financial risks of excess payments to borrowers whose property values don't go up as expected, or who live longer than the average person in their age bracket. To further reduce risks, the amount of the monthly payment would be tied to the age and sex of the homeowner, the amount of existing equity in the dwelling, and the amount of future appreciation the owner contracts to share. The company's financial structure, marketing system, and corporate strategy point to eventual expansion into other States based on market acceptance in New Jersey.

A reverse mortgage insurance plan was proposed by the Department of Housing and Urban Development in 1983. HUD's proposal was included in the Senate Banking Committee's authorization bill, S. 1338, and the House-passed authorization bill H.R. 1. The insurance plan had three basic purposes: (1) To meet the special needs of elderly homeowners by insuring the conversion of home equity into liquid assets; (2) to encourage and increase the involvement of lenders and secondary market participants; and (3) to permit evaluation of data regarding demand, supply, and appropriate Federal participation. The proposed demonstration authority provided for insurance coverage for up to 1,000 reverse mortgages through September 1986.

House-Senate negotiations on the HUD proposal led instead to language requiring HUD to evaluate existing reverse mortgage programs. Private studies analyzing various aspects of reverse mortgage insurance were started in November 1983. Under a grant from the Piton Foundation in Denver, the San Francisco Development Fund is conducting a feasibility study of a loan loss reserve pool for reverse mortgages. Additionally, a major mortgage insurer has begun to develop a private sector initiative.

Consumer safeguards for those participating in home equity conversion plans were the subject of continuing debate in 1983. Accordingly, in December 1983, the Administration on Aging announced a 12-month project to provide information, training, and technical assistance on home equity conversion. The project will produce operating materials based on the San Francisco Development Fund's RAM program and Buffalo's home equity living plans. Additional materials relating to deferred payment loans, sale/leasebacks, and consumer counseling will be developed and disseminated. The project will also provide direct training and technical assistance to local programs. The National Center for Home Equity Conversion (NCHEC) will be responsible for overall project administration, coordination, and for generating non-Federal matching funds to support the project.

A bill to clarify Federal tax treatment of residential sale/leaseback transactions made steady progress in 1983. Senator Specter's bill (S. 1914) was the subject of a factfinding session by the Federal Council on the Aging, and a hearing by the Senate Finance Subcommittee on Taxation and Debt Management.

The factfinding session and hearing uncovered three major areas of concern regarding the original bill: (1) A statutory definition of a "qualified" sale/leaseback should not create tax uncertainty for otherwise sound sale/leaseback transactions that may not precisely fit the definition; (2) the legislation should clearly spell out the extent to which future occupancy rights of the seller can be safeguarded without jeopardizing the tax status of the transaction; and (3) the bill should conform as nearly as possible to current provisions of the Internal Revenue Code, IRS rulings, and case law with respect to the taxability of residential sale/leaseback proceeds. A new version of the legislation that addresses policy concerns and technical issues that surfaced in testimony before the Federal Council and Senate subcommittee was in draft form at the end of 1983.

The National Center for Home Equity Conversion sponsored a 2-day national development conference on home equity conversion in July 1983. The conference included sessions on reverse mortgages and sale/leasebacks, and workshops covering insurance, second mortgages, marketing, and public policy.

## 2. SHARED HOUSING

Shared housing can be best defined as facilities housing at least two unrelated persons where at least one is over 60 years of age, and in which common living spaces are shared. It is a concept which targets single and multifamily homes and adapts them for elderly housing. Shared housing can be agency-sponsored where usually 4 to 10 persons are housed in a dwelling, or it may be a private home/shared housing situation in which there are usually three or four residents.

The economic and social benefits of shared housing have been recognized by many housing analysts. Perhaps the most easily recognized benefit is that a companionship for the elderly. Also, shared housing is a means of keeping the elderly in their own homes, while helping to provide them with the means to maintain these homes. In some instances, elderly who otherwise would be overhoused can help families who may be having difficulties in finding adequate housing arrangements.

From an economic viewpoint, shared housing can be an important low-cost means of revitalizing neighborhoods. Abandoned large houses and buildings could be made suitable for shared housing with very little renovation. As a new construction, Dennis Day Lower, director of the Shared Housing Resource Center in Philadelphia, has pointed out that shared housing is extremely cost effective when compared to new construction of housing for the elderly. He claims that per unit capital costs could be as much as 50 to 60 percent lower using shared housing.

There are various impediments to shared housing. Among the most prominent are zoning laws, reduced supplemental security income and food stamp payments to participants, and lack of section 8 rental assistance. Congress recognized the need to overcome these impediments, and has begun to act by including a provision in the Housing Act of 1983 for section 8 rental assistance to be used with shared housing. Under this provision, the existing and moderate rehabilitation program of section 8 can be used to aid elderly families in shared housing. HUD will issue minimum habitability standards to insure decent, safe, and sanitary housing conditions for such dwellings. The Housing Act of 1983 also included shared housing as an eligible activity under the community development block grant program.

Several shared housing projects are in existence today. Anyone seeking information in establishing such a project or looking for housing in a project can contact two knowledgeable support services. One is "Operation Match," which is a growing service now available in numerous communities throughout the country. It is a free public service open to anyone over 18 years of age with no sex, racial, or income requirements. Operation Match is a division in the housing offices of many cities, and helps match people who are looking for an affordable place to live with those who have space in their homes and are looking for someone to aid them with their housing expenses. Some of the people helped by Operation Match are single working parents with children, those in need of short-term housing, elderly people hurt by inflation or health problems, and the handicapped who require live-in help to remain in their homes.

The other source of information in shared housing is the Shared Housing Resource Center in Philadelphia. It was founded in 1981, and acts as a linkage between individuals, groups, churches, and service agencies that are planning shared households.

### 3. ACCESSORY APARTMENTS AND GRANNY FLATS

Accessory apartments have been in existence in this country for many years and have been accepted in communities across the Nation. These apartments were occupied by members of the homeowner's family, and, therefore, accepted into the neighborhood. Now, with affordable rental housing becoming more difficult to find, various interest groups, including the low-income elderly, are taking a closer look at this type of housing.

Basically, accessory apartments are another form of shared housing, except that each unit has its own kitchen. Thus, this form of housing undergoes the same zoning restrictions and impediments already discussed in the section of this report concerning shared housing. A few jurisdictions have modified local zoning rules to permit accessory housing, primarily in California.

Another innovative housing arrangement under discussion is the "granny flat" or "ECHO flat," first constructed in Australia and recently introduced in this country. "Granny flats" were constructed as a means of providing housing for elderly parents or grandparents where they can be near their families while maintaining a measure of independence for both parties. In the United States, we refer to such living arrangements as "ECHO units," acronym for Elder Cottage Housing Opportunity units. ECHO units are small, freestanding, barrier free, energy efficient, and removable housing units that are installed adjacent to existing single-family houses. Usually they are installed on the property of adult children, but can also be used to form elderly housing cluster arrangements on small tracts of land. They can be leased by nonprofit corporations or local housing authorities.

Rigid zoning laws, lack of public information, and concern about adverse changes to the neighborhood, and, therefore, property values, are the major barriers to the development of ECHO housing.

ECHO units are now in place in Frederick County, Md.; Lancaster County, Pa.; Fairfax County, Va.; and various locations in California. Ordinances in all of these jurisdictions require a family relationship between homeowners and occupants of the ECHO units. They also require that the occupant of one of the dwellings be elderly, meaning 60, 62, or 65 years of age, depending upon the ordinance. In a few exceptions, ECHO housing is open to nonelderly family members who are mentally or physically disabled. In all of these jurisdictions, no more than two persons may occupy one ECHO unit.

Many civic leaders, public officials, and organizations are reporting increased interest in the possibility of ECHO units for their jurisdictions. At this time, there is no Federal legislation dealing with this concept.

## B. RETIREMENT CENTERS, REST HOMES, AND OTHER LIMITED CARE FACILITIES

Although the Federal Government is supporting several congregate housing demonstration projects and a few States are establishing congregate housing programs, there is little direct public assistance to fill the gap between totally independent living arrangements and health-care-oriented nursing homes. Accordingly, the private sector has stepped in to provide various options ranging from low-cost rest homes and board and care facilities to expensive life care communities and retirement centers. Unfortunately, there is very little nationally aggregated information about the various forms of semi-independent living available to older Americans.

In the past, the Senate Special Committee on Aging has made a point of scrutinizing the Nation's estimated 300,000 board and care homes serving low-income older persons. The Aging Committee, in 1983, also conducted an investigative hearing on the benefits and shortcomings of the life care industry. One of the committee's major objectives in 1984 will be to learn more about the demand for and the conditions in the generally unsubsidized, and loosely regulated area of semi-independent living for the elderly.

### 1. Board and Care Homes

The more than 1 million residents of boarding homes, and foster, adult, or domiciliary care facilities are usually receiving some form of public assistance. Managers of the 300,000 such homes have often been criticizied for inadequate safety and security measures, poor care and abuse of the residents, and even financial fraud.

It was not until 1976 that public concern finally led Congress to require State licensing and regulation of these facilities. The Federal law, however, has had limited impact on the boarding home industry. In order to strengthen protections for residents in "board and care homes," the Federal Government may consider the provision of minimal levels of medical care and other supervision in addition to room and board, as well as enforcement of fire safety standards and other building design changes for physically impaired residents.

### 2. Retirement Centers and Life Care Communities

Middle income and more affluent older Americans often choose to live in retirement centers and life care communities rather than maintaining their own homes. Roughly 1 million people live in more than 2,300 such communities across the country. These multilevel care facilities generally offer a package of meals, social support services, and access to health care to elderly persons living in independent housing units. Sponsored by churches, labor unions, other nonprofit groups, and private companies, these communities vary from a single building to campus-like settings. Concerns about the problems of home maintenance, loneliness, and future health care notivate older Americans to seek the social benefits and financial security that these facilities provide.

## LIFE CARE COMMUNITIES

A subset of these retirement facilities, "the life care community," was the subject of a hearing by the Senate Special Committee on Aging on May 25, 1983. The hearing, entitled "Life Care Communities: Promises and Problems," marked the first time a congressional committee had addressed this fast growing and significant housing, service, and health care option for the elderly.

Life care is the concept whereby an individual, through a contractual arrangement with a life care facility, agrees to pay an entrance "endowment fee" ranging from $20,000 to $100,000 and a monthly "service fee" in return for the lifetime use of a living unit, the guarantee of lifetime nursing care as needed, and a variety of other services and amenities.

The life care industry has doubled in size in recent years and now cares for approximately 100,000 people. Because its rapid growth has been marred by a number of facilities that have gone bankrupt or been accused of fraud or misrepresentation, life care is at a critical point in its development.

The Aging Committee received testimony from residents of two life care communities, from a team of nationally recognized experts who advocate the increased development of life care, and from representatives of State and Federal law enforcement and regulatory agencies that have had experience with some of the unique problems associated with this industry.

Life care communities provide insurance against the cost of long-term care, and they supplement the coverage of acute care costs paid for largely by medicare and private insurance. The unique feature is that this otherwise unobtainable full insurance is provided in combination with living arrangements and social support. In a broader sense, life care communities provide a kind of combined health, housing, and social care insurance.

Elderly middle-class Americans seeking security against the future seem most attracted to life care. Commonly, the prospective life care resident is one who has owned his or her own home. Upon reaching retirement age, he or she decides to give up the responsibilities of maintaining a home and the money realized from the sale of the home may constitute the principal portion of the entrance fee for the life care contract, and may well represent the bulk of the individual's life savings. This year alone nearly 2 million Americans will reach age 65. Roughly 75 percent of them own their own homes, thus control a source of investment capital sufficient to gain them access to a life care community.

The staff of the Senate Aging Committee compiled the following analysis of the life care industry in preparation for the May 23d hearing.

*Facts:* Reliable data on the size of the life care industry is scarce. Nevertheless, depending upon definitions used, most observers agree that it is extensive and growing with at least 300 to 500 facilities in existence, housing some 100,000 residents. Revenues are projected to be approximately $1 billion per year.

Very few life care homes are totally proprietary although there is a growing interest in this industry by the for-profit sector. Today, one-half to two-thirds of the life care homes are nonprofit, while at least 33 percent of the homes are managed by for-profit contract managers.

Much of what is known about the general nature of the life care industry was brought about by a study jointly funded by the Robert Wood Johnson Foundation and the Commonwealth Fund and conducted under the auspices of the Wharton School at the University of Pennsylvania. The study, while not inclusive of all life care communities, is thought to contain data which are characteristic of the industry. The study found:

—Typically, a life care facility consists of apartments or residential units, a nursing care facility, and other service and recreation units in a campuslike setting.

—The average age of life care communities' residents is age 81.

—Based upon financial analysis of the equity elderly people have in their homes, hundreds of thousands of those who retire can afford life care.

—Twenty percent of all life care communities were found prior to 1960, 40 percent were built between 1960 and 1970, and the remaining 40 percent were constructed since 1970.

—With the exception of New York which prohibits life care arrangements, the distribution of life care communities throughout the United States follows the distribution of aged individuals. Over two-thirds of all life care communities are located in the following States (listed most to least number): California, Florida, Pennsylvania, Ohio, and Illinois.

—Contrary to the belief that once an individual enters a life care community health care services are a free good, the basic principle of "co-pay" is widely used.

—While approximately one-half of all life care communities include three meals each day as part of their basic fee structure, the trend in newer communities is to include only one meal, presumably to give residents more freedom in structuring optional services.

—Most life care communities are organized as nonprofit organizations with religious affiliations. Approximately one-third of the communities purchase management services from an outside organization, generally a for-profit organization, while the remaining are self-managed. The number of for-profit life care communities organized as real estate ventures appears to be increasing.

—Most successful life care communities have developed long waiting lines for the future.

*Problems:* The industry's growth has not been without its share of problems. Many life care communities have gone bankrupt and others appear to be financially unsound. In some cases these were due to shortsighted and inept management, in others they were due to deception and outright fraud. Typically, these operations get into financial trouble when current operating expenses get too high. Reserve funds which should only be used to retire long-term debts have been utilized to make up the shortfall.

A partial list of the types of problems that have been encountered in the life care industry include:

—Residents of life care communities are given no equity interest in the facility. Nor is their lifetime investment routinely protected by any form of insurance. When bankruptcy occurs, the senior citizen residents have no standing and can lose all of whatever they have paid into the home.

—Some life care communities have been financed as real estate ventures with endowment fees being used to cover initial construction costs. Reserves are either not established or they are set too low to cover future needs.

—Some life care communities function using lifespan and health projections that are not actuarially sound and projections of future revenues and costs are incorrect.

—Some homes use a "cash" accounting system rather than an "accrual" system thereby grossly inflating their cash position and misrepresenting their solvency.

—Some contracts are written in such a way that if a person decides, even within a reasonable period of time, that he or she does not want to stay at the facility, the entire endowment is lost and not returned even on a prorated basis.

—Some life care communities represent themselves as being affiliated with a religious denomination or church, giving the impression that those entities would back the operation if any serious financial problem should develop. Quite often this claim has turned out to be false.

—In the past, almost all life care facilities were church related. Recently, however, there has been a growth of private, nonprofit corporations which sponsor life care facilities. While the individual facility is clearly nonprofit, the corporation that organizes and develops the project is often a for-profit organization. The profitmaking goals of the developer may conflict with the financial stability of the nonprofit corporation, e.g., in order to attract consumers and quickly raise funds, the pricing structure may be established too low to provide both profit and future financial stability.

—Some life care communities have led residents to believe that the mortgage lender, such as a major bank or insurance company, insures the economic security of the life care home when they do not. In fact, in the event of bankruptcy the residents' life care contract does not even have the preferred status of other creditors.

—Some life care communities accept an individual's large endownment fee for a lifetime of housing and health care and as soon as the individual needs nursing care declares the person financially destitute and seeks to qualify the individual for State medicaid benefits.

The problem of the life care industry raise complicated and unique regulatory issues that deserve the attention of the legislature and executive branches at both the Federal and State levels.

*Regulation:* Being a relatively new and growing phenomenon, life care is just beginning to be understood and regulated. California, in 1969, was the first State to regulate life care. Today only 11 States regulate the operation of life care communities. These States are: Arizona, California, Colorado, Florida, Illinois, Indiana, Maryland, Michigan, Minnesota, Missouri, and Oregon. New York, which bans prepaid nursing home care, effectively prohibits life care arrangements. There is little uniformity in the way these facilities are regulated by the States. Some States require operators to make public ownership and financial disclosures, others do not. Similarly, some States regulate resident rights and others do not. Few if any of the States offer adequate protection from the operator who deliberately seeks to use complex profit/nonprofit business structures and non-arms-length transactions to enhance his personal wealth at the expense of the life care residents.

Experts associated with the Robert Wood Johnson Foundation study have suggested that States, when regulating life care, should address issues such as: Facility certification and accreditation; management of escrow accounts; maintenance of reserve funds; required financial disclosure; form and content of life care contract; advertising; strengthening preconstruction disclosure requirements for bond holders; and the development of methodologies to be used to test the ongoing financial viability of the community.

While certain Federal agencies such as the FTC, SEC, HHS, HUD, and FBI have from time to time been involved in limited aspects of life care, there is no significant, direct Federal involvement in this industry at this time. It is clear that if any comprehensive Federal response is to be developed it will need to come from some congressional initiative. Congress has already considered several early bills that addressed the life care phenomenon and more are sure to come. Indeed, it is reported that at least one member of the Aging Committee is actively examining the possibility of introducing Federal life care legislation.

Life care can become increasingly significant for growing numbers of people and for the society as a whole. But just as clearly, potential residents need to understand the nature of the financial risks involved and each facility must be soundly based and operated under adequate financial planning. Otherwise the promise of life care can become illusory and the loss to residents catastrophic.

# Chapter 16

# ENERGY ASSISTANCE AND WEATHERIZATION

## OVERVIEW

Ten years ago, Arab oil ministers meeting in Kuwait agreed to cut oil exports by 5 percent and recommended an embargo against unfriendly nations. Shortly after this meeting, Saudi Arabia instituted a full-scale embargo on oil sales to the United States—other members of OPEC quickly followed. The "energy crisis" was in full swing.

The radical changes in world oil markets following the 1973 embargo brought equally radical changes in household budgets of Americans. The proportion of income required to purchase essential energy supplies rose dramatically, and changes in the cost of this basic commodity brought changes in the cost of many other necessary items. Although these changes had different impacts depending on a household's income and fuel requirements, during the past 10 years the pressure for change in consumption patterns and the erosion of real spending power have been unrelenting. The rising cost of energy has had a particular effect on the elderly and those with low incomes, who consume relatively less energy than other households, but pay a larger portion of their disposable income for fuel.

During the past several years, a number of Federal programs have been implemented to provide energy assistance to the low income and elderly. The most significant of these programs are the low-income energy assistance program and the Department of Energy's weatherization program. Over the years both programs have undergone repeated modifications in response to both growing need and apparent deficiencies in the programs.

The current low-income energy assistance program (LIEAP) and DOE weatherization program are authorized by the Omnibus Budget Reconciliation Act of 1981. Under the LIEAP program the Secretary of Health and Human Services (HHS) provides grants to States for the purpose of making financial assistance available to low-income households with home energy costs that are excessive in relation to household incomes. Funds are provided in the form of direct cash assistance, direct payments to fuel vendors, or payments to public housing building operators. The weatherization assistance program, on the other hand, is designed to help households that simply lack the cash or credit with which to respond to the current incentives for conservation. The program provides grants to States to improve the energy efficiency of low-income homes.

In the 1983 budget request, the administration proposed to replace LIEAP with a block grant, and requested no funding for the weatherization program. It also proposed to dismantle the Department of Energy. Although Congress studied numerous energy assistance proposals, it rejected the administration's approach, and decided to continue the programs essentially the same as they operated in fiscal year 1982.

The LIEAP is currently authorized for each of the fiscal years 1982, 1983, and 1984, at a funding level of $1.875 billion. For fiscal year 1983, this program operated under a continuing resolution. During deliberations on this resolution Congress added $100 million to the program, bringing the annual appropriation for fiscal year 1983 to $1.975 billion.

For fiscal year 1983, the weatherization program was funded under the Interior Appropriations Act (Public Law 97-394) at a level of $145 million. Additionally, during this fiscal year, an emergency jobs-creation supplemental appropriation was passed by the Congress and signed by the President (Public Law 98-8), providing an additional $100 million for the weatherization program—thus, bringing the annual appropriation to $245 million.

## A. NEED FOR ENERGY ASSISTANCE

The critical question for low-income households is what proportion of the total household budget is being paid for home energy costs and to what extent real incomes have kept up with energy inflation. The rise in energy costs in relation to income has been the impetus behind congressional enactment of the low-income energy assistance program and the low-income weatherization program. In the 5-year period, 1972 to 1979, electricity costs rose 84 percent, gas 150 percent, and fuel oil costs 258 percent. These figures were well above the overall increase of 74 percent in the Consumer Price Index for the same period. The following table illustrates the dramatic increase in the average cost of home heating between 1980 and 1982, by region and fuel source. Although the actual dollar amount increases may vary with different surveys, the overall trend in energy costs is consistent.

## ESTIMATED AVERAGE COST FOR HOME HEATING

| Census region | 1980 | 1982 [1] |
|---|---|---|
| Fuel oil/kerosene: | | |
| Northeast | $1,000 | $1,709 |
| North Central | 1,040 | 1,489 |
| South | 530 | 1,228 |
| West | 730 | 941 |
| Natural gas: | | |
| Northeast | 530 | 1,248 |
| North Central | 560 | 1,030 |
| South | 300 | 932 |
| West | 350 | 726 |
| Electricity: [2] | | |
| Northeast | 690 | 1,183 |
| North Central | 730 | 841 |
| South | 350 | 931 |
| West | 470 | 773 |

[1] Source: Energy Information Administration, Department of Energy. U.S. Average Residential Energy Expenditures for All Fuels Used in Households, by Main Heating Fuel Types (Dollars per Household).

[2] Figures utilized are for electricity as main heating fuel without air-conditioning.

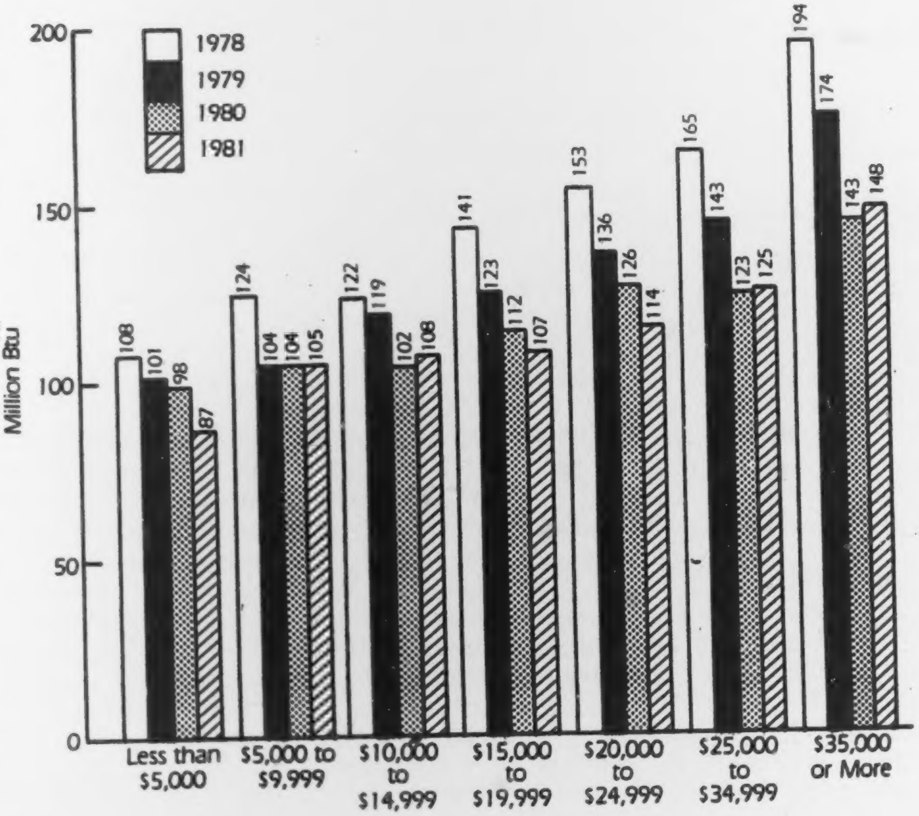
The Residential Energy Consumption Survey prepared by the Department of Energy for the period April 1981 through March 1982, indicates that 56.4 percent of elderly households (60 years and over) heat with natural gas, 22.2 percent depend on electricity, 17.2 percent utilize fuel oil or kerosene, and 4.2 percent use liquid petroleum gas.

The Department of Energy has estimated that in 1981, as in previous years, energy consumption is higher for households with larger incomes. Chart 1 displays the average consumption of fuel per household by income class for a 4-year period. There is a large difference in average energy consumption and expenditures among households with different incomes. The highest income households use about 70 percent more energy than the lowest income groups in part because the living quarters of the high income are about twice the size of the lowest income group and contain more appliances. From 1978 to 1980 there as a trend toward parity, with high-income households lowering their energy consumption more than did low-income households. The data for 1981, however, show a slight reversal of this trend. Households earning less than $5,000 reduced their consumption by an estimated 11 million Btu, while households with incomes over $24,000 did not show a continued drop.

## CHART 1

## AVERAGE TOTAL ENERGY CONSUMPTION
## BY INCOME CLASS - 1978 - 1981

(Million Btu per household)



Source: Energy Information Administration, 1978, 1979, 1980, and 1981 Residential Energy Consumption Surveys.

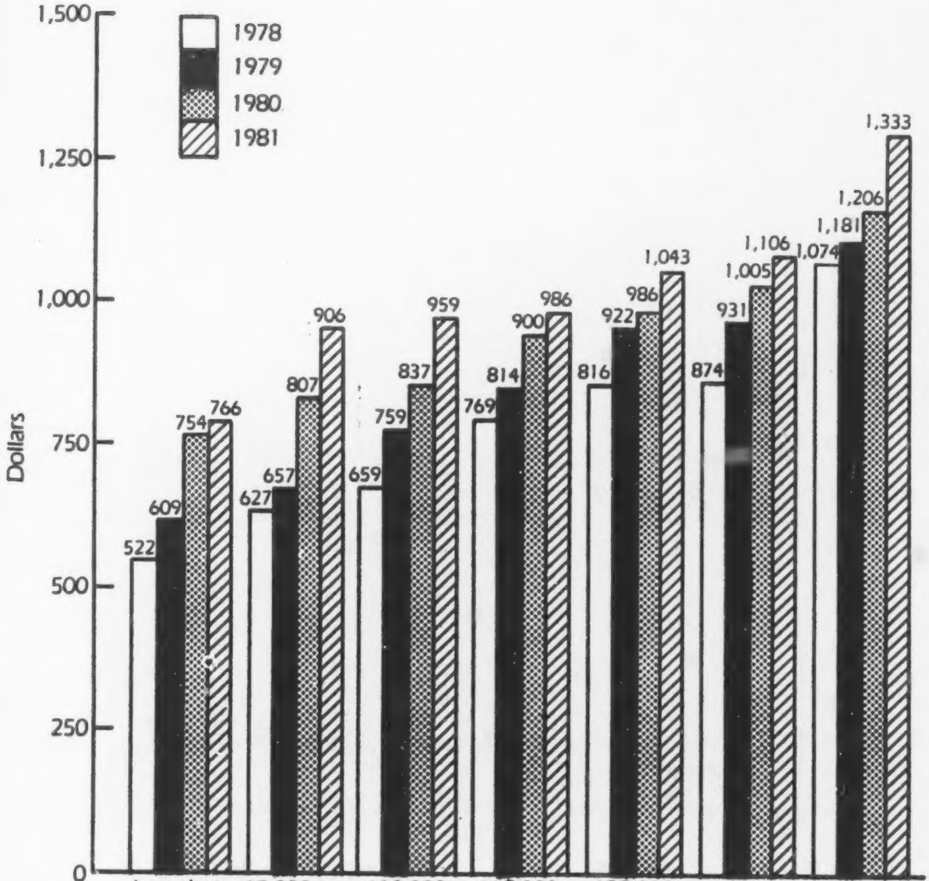
Rising energy prices affected all income groups, so that energy expenditures increased from 1978 to 1981 as shown in chart 2. Expenditures for households in the highest income group averaged $1,333, almost 75 percent more than expenditures for the lowest income group which were $766. In contrast, however, expenditures increased much more for the lower income group than for the higher. During the 4-year period beginning in 1978, expenditures for the lowest income group increased 47 percent (in nominal dollars) while expenditures for the higher income group increased 24 percent. Additionally, expenditures as a percentage of income are much higher for lower income groups, as shown in chart 3. Low-income households typically spent about 20 percent of their income on energy compared with 3 to 4 percent expended by high-income households.

CHART 2

AVERAGE TOTAL ENERGY EXPENDITURES

BY INCOME CLASS: 1978 - 1981

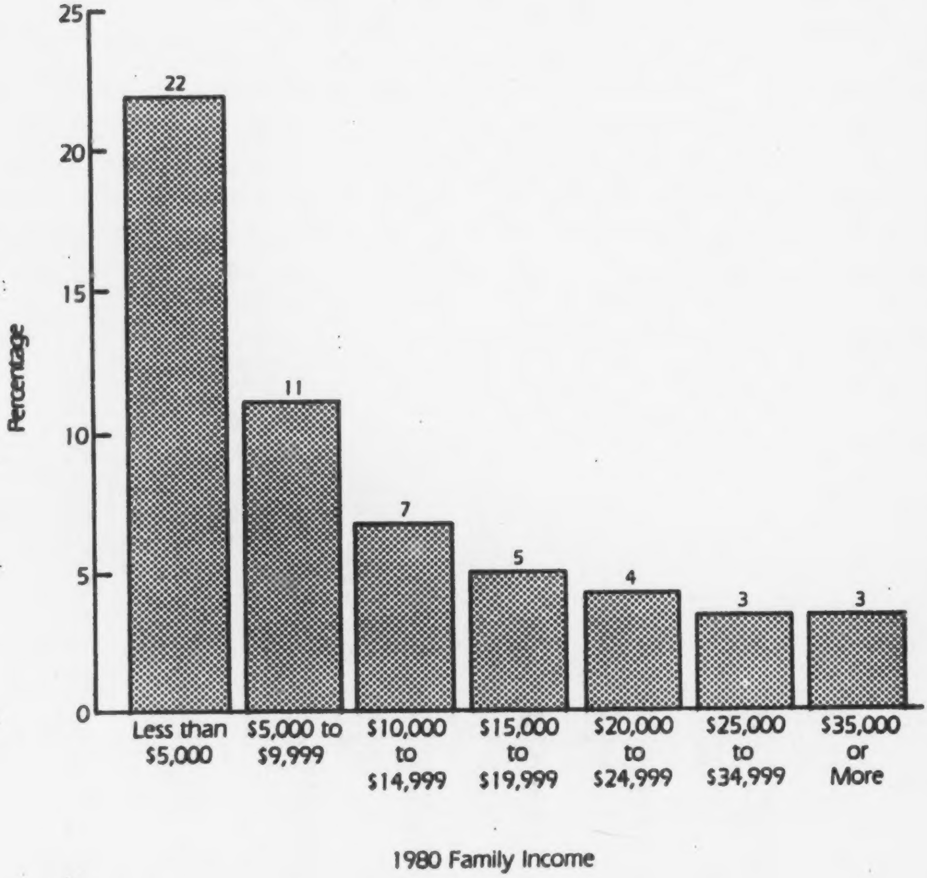
(Nominal Dollars per Household)



Source: Energy Information Administration, 1978, 1979, 1980, and 1981 Residential Energy Consumption Surveys.

## CHART 3

## PERCENTAGE OF INCOME SPENT ON HOUSEHOLD ENERGY, BY INCOME CLASS - 1981



Note: Household energy includes all uses of natural gas, electricity, fuel oil or kerosene, and LPG. It does not include motor gasoline.

Source: Energy Information Administration, 1981 Residential Energy Consumption Survey.

The situation is even worse for the low-income elderly because they are particularly susceptible to hypothermia—the potentially lethal lowering of body temperature—and to heat stroke. The Center for Environmental Physiology in Washington, D.C., has reported that experts on this subject estimate that hypothermia may be the root cause of death for up to 25,000 elderly people each year. The center reports that most of these deaths occur after exposure to cool indoor temperatures rather than extreme cold, and that the situation can worsen many preexisting conditions and diseases in older adults. Although another disease is ultimately listed as the cause of death, the center maintains that many deaths may be causally related to hypothermia. In addition to this problem, experts estimate that as many as 2,000 deaths among older Americans were directly attributed to the heat wave of 1980. To protect themselves against these serious threats to health, the elderly often should be using more energy than they do.

## B. ENERGY ASSISTANCE PROGRAMS FOR FISCAL YEAR 1983

Congressional efforts to ease the burden of high energy costs on the elderly have taken two principal forms. First, since 1977, Congress has appropriated money to provide aid for fuel-related emergencies to households at or below 125 percent of the poverty line. The low-income energy assistance program grew from $200 million in "crisis assistance" in 1977, to $1.975 billion in fiscal year 1983. Funds were distributed to States according to climate and energy needs of the population.

Second, in 1975, Congress enacted the emergency energy services conservation program, designed to provide energy relief to needy households by increasing the energy efficiency of homes through insulation and repair. This developed into a $180 million weatherization program operated by the Department of Energy. During fiscal year 1983, this program was funded at a level of $245 million.

### 1. The Low-Income Energy Assistance Program (LIEAP)

The precursors of the current low-income energy assistance program were a series of 1-year programs in fiscal years 1977–79 that were administered by the Community Services Administration. Although the names and operating procedures of these programs differed year to year, they all were limited to a $200-million annual appropriation and oriented to crisis intervention. Generally, potential low-income recipients had to demonstrate that they faced an imminent energy-related emergency, such as shutoff of their home heating fuel supply or breakdown of their primary heating source. In such cases, aid could be provided to pay utility bills or provide in-kind benefits, such as space heaters or blankets.

Between the winters of 1979 and 1980, the price of home heating oil doubled. In response, Congress expanded aid sharply by creating a three-part energy assistance program at an appropriation level of $1.6 billion: $400 million in CSA for continuation of its crisis intervention programs; $400 million to the Department of Health and Human Services (DHHS) for one-time payments to recipients of supplemental security income (SSI); and $800 million to DHHS for distribution as grants to States to provide supplemental energy allowance.

For fiscal year 1981, Congress passed the Home Energy Assistance Act of 1980 as part of the crude oil windfall profit tax. The act authorized $3.12 billion for LIEAP in fiscal year 1981. During the appropriation process, however, the funding level and the distribution formula were changed. In its final form, $1.85 billion was appropriated, and the distribution to States was based on a complex formula that was heavily weighted toward States with cold climates and large fuel oil consumption.

Although each State designed its own LIEAP program, an extremely detailed plan had to be submitted and approved before a State could receive its funds.

Low-income energy assistance program funds were reauthorized for fiscal year 1982 through fiscal year 1984, in Public Law 97-35, the Omnibus Budget Reconciliation Act of 1981, at $1.875 billion for each fiscal year. Under the act, the Federal Government distributes the funds to the States and the States, in turn, design the programs and administer the assistance payments.

Three basic types of energy-related aid are permissible under the LIEAP. States may make payments to assist households in paying their fuel bills for either heating or cooling. There are virtually no restrictions on the manner in which this assistance is provided (cash payments, vouchers, vender lines of credit, and tax credits are the most common). States must use a "reasonable" amount of their allotment to provide energy-related emergency assistance, such as that provided under the old CSA crisis intervention programs. Finally, States may use up to 15 percent of their allotments for low-cost weatherization. Up to 10 percent of a State's allotment may be transferred from LIEAP to other Federal block grant programs and conversely, funds may be transferred into LIEAP from other block grants.

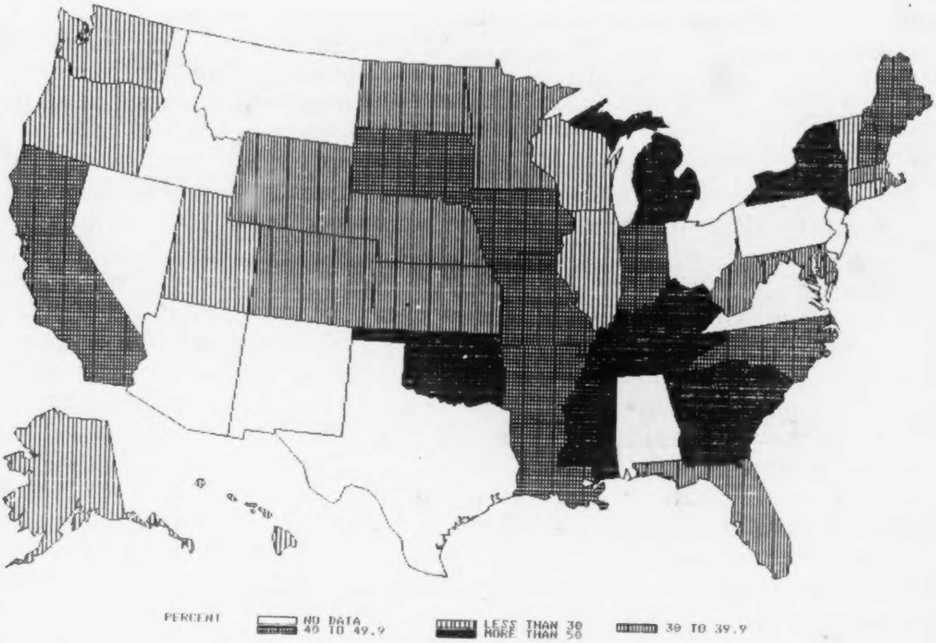
### (A) EFFECTIVENESS OF SERVICES TO ELDERLY: 1981-82

The low-income energy assistance program requires that elderly and handicapped citizens be given priority in receiving assistance. This provision was intended to assure that elderly and poor households are aware that help is available, thus avoiding unnecessary shutoff of utility services. Chart 4 indicates the percentage of applicant households with elderly members, which provides a picture of how successful State outreach efforts have been in identifying and serving the elderly. Because many of the reporting requirements have been relaxed in recent years, some States have not kept data on the numbers of elderly who have benefited from LIEAP.

Although States have come up with a variety of means for implementing the targeting requirement, several aging organizations have suggested that Older Americans Act programs, especially senior centers, be utilized as an information/referral and outreach base. Discussions with area agency on aging and senior center staff indicates that increased effort has been made in recent years to identify eligible elderly persons for LIEAP assistance.

CHART 4

PERCENT OF HEATING ASSISTANCE HOUSEHOLDS CONTAINING AT LEAST ONE ELDERLY PERSON



### (B) LIEAP FUNDING FOR FISCAL YEAR 1983

In the fiscal year 1983 budget, the Reagan administration proposes to consolidate into one program the existing low-income energy assistance program and the emergency assistance grant program under title IV of the Social Security Act. For fiscal year 1983, and each year thereafter, $1.3 billion was requested for this purpose. The request represented more than a 30-percent reduction in total funding for these two programs. Like the food stamp program, the low-income energy assistance program was included in the President's New Federalism plan and would eventually become a State responsibility.

In September 1982, the House Appropriations Committee reported its fiscal year 1983 spending bill, H.R. 7205, which included $1.875 billion for LIEAP. Because H.R. 7205 did not complete its way through the legislative process, the program was funded by a continuing resolution. During Senate debate on the continuing resolution, a Danforth amendment to increase the appropriation by $200 million for LIEAP was agreed to. However, subsequent action during Senate-House conference discussion, limited the increase to $100 million. The LIEAP was, therefore, funded by a continuing resolution (Public Law 97-377) through September 30, 1983, at an annual level of $1.975 billion.

## 2. THE DOE WEATHERIZATION ASSISTANCE PROGRAM

The Department of Energy weatherization program is authorized by title IV, part A, of the Energy Conservation and Production Act of 1976, as amended in 1978 and 1980. Persons below 125 percent of poverty are eligible for assistance, as in the LIEAP program, priority is given to the elderly and handicapped. Weatherization assistance is designed to help those households that lack the cash or credit with which to respond to the current incentives for conservation.

Benefits of the program are threefold. First, improving the energy efficiency of a home provides greater comfort with less consumption. Second, weatherization improvements are permanent; energy savings accrue each year on a one-time investment. Third, reducing consumption reduces fuel bills for those low-income households, thereby lessening the demand for LIEAP funds. The program has been administered through State energy offices, State economic opportunity offices, and locally through community action agencies (CAA's) and others. There has been a "preference" but not a mandated priority for CAA's, which remain the principal delivery system.

The weatherization assistance program provides for the installation of insulation, storm windows and doors, and other energy efficiency improvements up to $1,000 per unit. Labor is to be provided by other sources. However, a waiver can be granted if no other labor is available, with the total cost then limited to $1,600.

Although specific statistics from States on the number of elderly served were not consistently available, DOE has reported that most of the dwellings that have been weatherized were occupied by older people.

In the past, the program has been criticized by the Congress and the General Accounting Office for delays, poor performance, and management problems. One of the key obstacles to program success was the requirement that weatherization funds be used primarily for materials, which left inadequate funds for labor and program administration. With the phaseout of CETA this problem has become more severe.

In general, despite delays in funding, the weatherization program has maintained its productivity. It is believed that the percentage of elderly participants has risen steadily. A recent study by the Consumer Energy Council of America found the weatherization effort to be particularly successful in three critical areas.

First, in terms of energy savings, an average investment of $968 reduced energy consumption 26 percent, achieving savings almost as good as those realized in pure research conditions. Second, in economic terms, low-income weatherization is more labor intensive than any fuel production option, creating more jobs per dollar invested. Finally, as a social benefit, weatherization results in savings to low-income households of up to 27 percent in their fuel bills (4 percent of their average annual income). This benefit will increase as home fuel prices continue to increase.

### (A) WEATHERIZATION FUNDING FOR FISCAL YEAR 1983

In its 1983 budget request, the administration requested no funding for the Federal weatherization program. The administration proposed to eliminate categorical funding altogether for the program, along with the dismantlement of the Department of Energy. Congress rejected this proposal. Weatherization programs are currently funded under the Interior appropriations of 1983 (Public Law 97-394) at a level of $145 million.

In addition to continuing funding for the program, Congress also blocked attempts by the Department of Energy to limit per unit expenditures to a ceiling of $500. Previous law set the unit expenditures at $1,000 per dwelling unit for materials. Provisions in the Interior Appropriations Act of 1983 state:

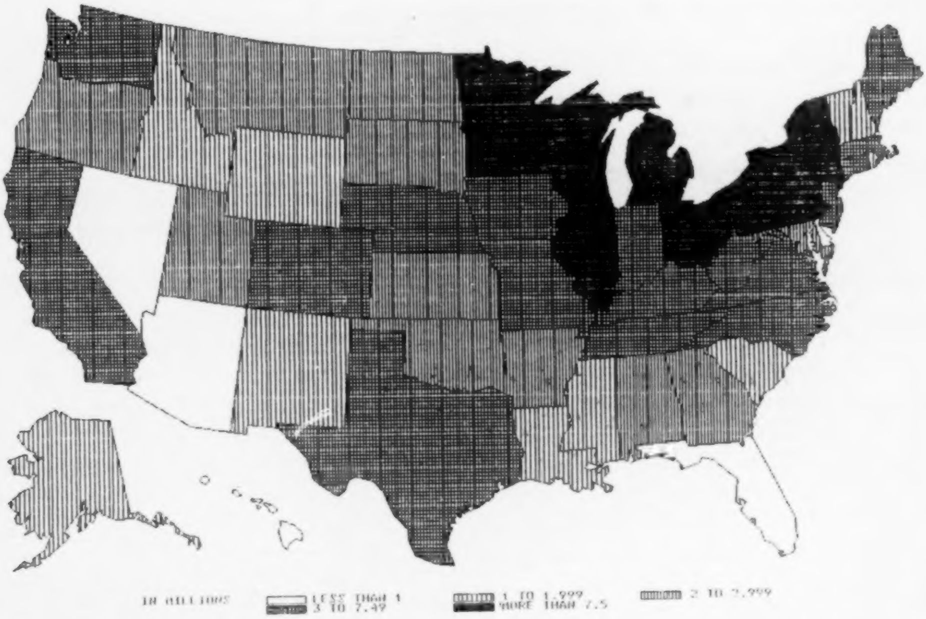
> * * * funds for low-income weatherization activities appropriated under the act shall be expended according to the regulations pertaining to the maximum allowable expenditures per dwelling unit which were in effect on October 1, 1982 * * *

The $1,000 per unit maximum will therefore remain in effect throughout the 1983 fiscal year.

In addition to the regular appropriation, Congress passed an emergency jobs-creation supplemental appropriations during fiscal year 1983, providing an additional $100 million for the weatherization program. The President signed this bill into law (Public Law 98-9) on March 24. Charts 5 and 6 display the total allocation and the per capita spending for the weatherization program for fiscal year 1983.

CHART 5

1983 WEATHERIZATION FUNDING
TOTAL ALLOCATION



SOURCE: DEPARTMENT OF ENERGY

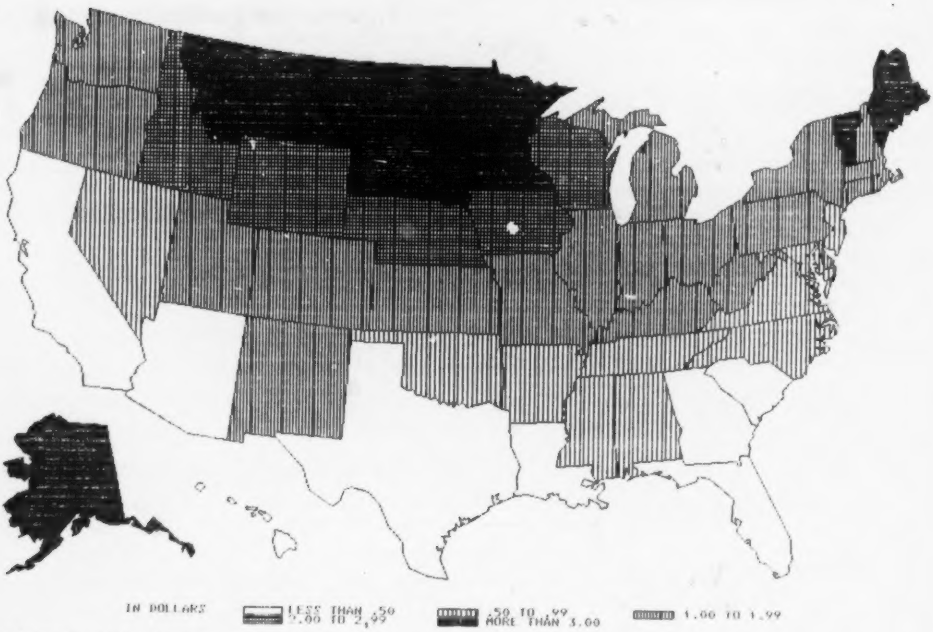
## C. AGING COMMITTEE ACTIVITIES FOR 1983

For more than 12 years, the Special Committee on Aging has been concerned with the acute problem of energy and the elderly. The committee has documented that some older Americans pay up to 50 percent of their incomes for home fuel. The committee has also been responsible for language in energy assistance legislation mandating priority for the elderly, and for oversight of the operations of these assistance initiatives.

In light of the administration's significant proposal to decontrol natural gas, the committee held an oversight hearing on March 17, entitled "Energy and the Aged: The Impact of Natural Gas Deregu-

CHART 6

1983 WEATHERIZATION FUNDING
PER CAPITA SPENDING



SOURCE: DEPARTMENT OF ENERGY

lation." The hearing examined the rapid rise in natural gas prices and considered the impact that the decontrol proposal would have on the elderly. As committee Chairman John Heinz explained in his opening remarks:

> First, we would like to examine the impact of current price increases in natural gas to residential consumers, along with the problems that elderly consumers are having in paying their utility bills, and the extent to which the elderly are threatened by utility cutoffs.
>
> Second, we want to review the effects of anticipated price changes in natural gas under the administration's proposal on elderly consumers, and the appropriateness of

> consumer safeguards included in the administration's proposal.
>
> Third, we want to explore the adequacy of current Federal resources that will be needed in the future to offset projected increases in energy costs themselves, and our ability to continue to assist low income and elderly consumers with their energy bills.

Senator Glenn, the ranking minority member, observed:

> * * * many elderly persons have literally had to choose between heating and eating. The proposed deregulation of natural gas presents another threat to the economic and physical health of elderly persons * * *. I believe that the administration's proposed deregulation of natural gas prices and its budget cuts for low/income energy assistance and weatherization raises serious questions about its willingness to provide adequately for the needs of low/income and elderly Americans.

Senator Percy warned of potential health threats to the elderly during the winter months:

> * * * Elderly people on fixed incomes have been particularly hard hit by these increases (fuel costs). They face a no-win situation. They are forced to pay more to heat a home. They have to take money away from other necessities, like food or clothing. Sometimes, they turn thermostats way down at serious risk to their health.

The hearing's first witness was Secretary Donald Hodel from the Department of Energy. Secretary Hodel explained and requested support for the administration's proposal to decontrol natural gas prices stressing that it rationalizes the gas market so that adequate supplies of gas could be provided at reasonable prices. He indicated his belief that as the free market works, the price of gas would drop compared to where it would have been under the Natural Gas Policy Act. In relating to the concerns of consumers, Secretary Hodel explained:

> While our legislative proposal is aimed at protecting all consumers from excessive gas prices, we are sensitive to the problems of elderly citizens with fixed and low incomes who are particularly vulnerable to rising gas prices * * *. Under our proposal, pipelines will be prohibited from automatically passing through price increases above the rate of inflation. Gas cost that exceed the rate of inflation must be examined and approved by the Federal Energy Regulatory Commission * * *. Further, the legislation proposes a "gas price cap" based on the average of gas purchased through new renegotiated contract following enactment as another consumer safeguard.

Other witnesses at the hearing included representatives of aging and consumer groups, a State level public utility commission, and a representative of gas suppliers. All found some fault with the administration's proposal, and provided some suggestions for public policy consideration. By the end of the first session of the 98th Congress, the Senate was still debating various proposals for deregulating natural gas.

A second major committee undertaking during 1983 was the publication of a print entitled, "Heat Stress and Older Americans: Problems and Solutions." The print proved to be timely, based on the fact that during the summer of 1983 several heat waves hit the country. In general, it was noted that the vast majority of communities throughout the country are unprepared to deal with the emergencies brought about by heat waves. The print notes that thousands of elderly persons run the potential risk of falling victim to heat stress, and that the Federal Government has an important leadership role to play in anticipating and planning for heat waves. The publication provides information on the scope of the heat stress problem on the elderly, and discussed preventive health concepts and ideas for community planning.

Finally, the committee helped draft legislation to reauthorize the DOE weatherization program. On October 17, 1983, committee Chairman John Heinz introduced S. 1953, the Weatherization Act of 1983. The legislation amends the Energy Conservation in Existing Buildings Act of 1976 to reauthorize for 3 years the weatherization program. In addition, the bill would improve the cost effectiveness of the existing program by allowing for furnace retrofitting and replacement of heating systems, and the application of energy efficient technologies. The legislation also provides for improved planning on the part of the Department of Energy and the States in carrying out the weatherization program. S. 1953 was referred to the Senate Committee on Labor and Human Resources. While this bill is still under consideration, the DOE weatherization program remains in place funded at a level of $191 million for fiscal year 1984.

# Part V

## SOCIAL SERVICES

Social service programs funded by the Federal Government support a broad range of services to older Americans. These programs provide funds to operate a wide variety of community and social services including senior centers, home health programs, legal services, education, transportation, and volunteer opportunities for the elderly.

In contrast to the entitlement programs—social security, SSI, food stamps, medicare, and medicaid—these programs are funded by discretionary appropriations from the general fund. They constitute a much smaller portion of the Federal budget devoted to older Americans than do entitlements. Since 1981, these discretionary programs have been decreasing in relationship to GNP. Based on the Reagan administration's policy to curb Federal spending for domestic programs and return responsibility for such programs to the States, many of these programs have experienced substantial cuts as they have been folded into block grants.

Currently, the most important and visible social service program which benefits persons over 60 is the Older Americans Act. The passage of the 1981 amendments to the act reaffirmed strong and continued congressional support for the programs funded under its auspices. The amendments provided for a 3-year reauthorization, with relatively minor modifications. Most of the changes were designed to provide greater flexibility to State and area agencies on aging. The Older Americans Act has grown over the years from a few small social service grants and research projects to a complex system of community services which are administered by 57 State and territorial units on aging and over 600 locally based area agencies on aging. In addition to funding basic social and nutritional programs, the act has fostered the development of other important services at the local level, including employment for older adults, counseling, home health care, transportation, day care, housing services, and many more.

For fiscal year 1983, Older Americans Act programs were funded under the authority of a continuing resolution. This resolution and a subsequent supplemental appropriation provided over $1 billion in funding for these programs with the largest share directed at supporting State and area agencies on aging ($643.4 million). In addition, $319.5 million was provided for the senior community service employment program and $100 million was allocated for the USDA commodities program.

Among the major issues likely to be considered by the Congress prior to reauthorization of the act are a review of the organizational status of the Administration on Aging, the need for more precise targeting of services under title III, the role of the aging network in providing community-based long-term care, the utilization of data related to research and demonstration programs, the administrative placement of the title V program, and the transfer of funds among title III categories. Although a host of other issues have been raised, most observers believe that no major restructuring of the act will occur during the 1984 reauthorization process.

Another major service program designed for older persons is provided under the older Americans volunteer program (OAVP). The OAVP, which includes the retired senior volunteer program, the foster grandparent program, and the senior companion program, is the largest of the ACTION agency program components. For fiscal year 1983, OAVP funding accounted for 69 percent of total ACTION funding, and supported the majority of ACTION's volunteer strength. Volunteers, who must be 60 years of age or older, work part time in a variety of community service activities. Project grants are awarded to local private, nonprofit, or public sponsoring agencies which recruit, supervise, and support volunteers. During 1983, legislation was passed in both Houses of Congress to reauthorize the Domestic Volunteer Service Act of 1973, thus extending the OAVP for a 3-year period. The older American volunteer programs operated at a level of $87.9 million during fiscal year 1983.

Although programs under the Older Americans Act and OAVP were designed primarily as categorical grants to aid older persons, to a lesser extent other Federal discretionary programs also provide services, and in some cases, are required to give priority in the provision of services to the elderly. They include legal services, the social and community service block grants, transportation, and education.

The need for continued legal advocacy that safeguard the civil rights of older persons in such areas as consumer affairs and protective services as well as in relation to the major public benefit programs, has been repeatedly recognized by the Congress. The Legal Services Corporation (LSC) has been at the forefront in providing access to legal services for the needy. Created in 1974 as a private nonprofit organization, the Corporation funds States and local agencies that provide free civil legal assistance to the poor. Recognizing that much of this target population is elderly, the LSC has made special efforts in recent years to address their needs. At present, the legal services community offices are the major source of legal assistance to the low-income elderly. In addition to these local programs, the Corporation funds a number of national support centers which develop and provide specialized expertise on the legal service needs of the elderly poor. The most current information indicates that approximately 14 percent of the total LSC caseload involves clients over age 60.

Since 1981, the Reagan administration has requested that the Legal Services Corporation not be reauthorized, and that no further separate Federal funding be provided. In justifying this phaseout, the administration noted that funds under the social service block grant could be utilized to provide legal service activities. In addition, the administration called on private attorneys to increase free services to the indigent in accordance with the legal profession's ethical obligations. Congress has consistently rejected the abolishment of the Corporation, and funded the LSC at a level of $241 million during fiscal year 1983.

The social services block grant (SSBG) was established by the Omnibus Budget Reconciliation Act of 1981. Previously operated as title XX of the Social Security Act, the program authorizes payments to States for a wide range of community social services for individuals and families. The former title XX program was designed to prevent or reduce dependency, prevent neglect and abuse, and prevent or reduce inappropriate institutionalization. In addition, the program contained certain provisions to target needy populations. Although many States have retained these components and objectives under the block grant, they are essentially free to design their own social service programs. During fiscal year 1983, the social service block grant was funded by continuing resolution at a level of $2.45 billion. Further, during 1983, an emergency jobs bill that was passed by the Congress and signed by the President provided an additional $225 millon for the program.

The community service block grant (CSBG) was established as result of passage of the Omnibus Budget Reconciliation Act of 1981. Prior to 1982, a variety of antipoverty programs were carried out by a network of over 850 community action agencies which were federally administered by the Community Services Administration. The community services block grant abolished the Community Services Administration (CSA) and replaced its activities and funding under the administrative authority of the Office of Community Services in the Department of Health and Human Services. The Reconciliation Act of 1981 authorized annual funding of $389.4 million, with States receiving allotments based on the amounts they received from CSA in fiscal year 1981. Under the 1983 continuing resolution, Congress appropriated $360.5 million for this block grant. An additional $25 million was provided for CSBG programs during fiscal year 1983 as a result of passage of an emergency job-creation supplemental appropriation.

Access by the elderly to social service programs often depends on the adequacy and availability of transportation. Often viewed as the vital link between home and community, transportation programs are essential in helping older people fulfill their most basic needs. Assistance for the elderly in accessing transportation can be provided under a number of Federal programs, including the Older Americans Act and the social service block grant. In addition, assistance to special populations is provided under the Urban Mass Transportation Act (UMTA) through a variety of formula and discretionary grant programs. The majority of funds provided under these grant sections of UMTA are reserved for capital projects, planning activities, demonstrations, and research. Funding is designed to expand access to the elderly and handicapped in both urban and rural areas, by providing capital and operating funds to transit systems, nonprofit organizations and municipalities to operate specialized systems. In addition, moneys are also used to provide reduced fares to the elderly and handicapped on existing mass transit systems during nonpeak hours.

Finally, with the "graying" of the American population, and a trend toward programs geared toward promoting self-sufficiency, educational progams explicitly directed toward older adults have emerged. The role of the Federal Government in education has been a limited one—to insure equal educational opportunity, enhance the quality of education, and address national priorities in training. State and local governments have had the primary responsibility for educating adults and older citizens, with some limited participation from the private sector.

The Adult Education Act (Public Law 91-230) authorizes the Department of Education to provide funds for educational programs that benefit all segments of the adult population. The purpose of the act is to establish programs that will enable adults to acquire basic skills, and if they so desire, continue with their education. The number of persons 65 and older participating in these adult education programs has grown at the average rate of 30 percent every 3 years. It is estimated that over 768,000 older adults were enrolled in such programs during 1981.

Even though these gains have been impressive, most observers believe that the educational system in the United States has failed to address the unique needs of older, illiterate adults. In response to a recent report concerning the quality of education in America conducted by the Commission on Excellence in Education, the Reagan administration made the elimination of illiteracy a major public policy goal in 1983. As a result, the Department of Education, in conjunction with the private sector, has sponsored the adult literacy initiative, which is designed to support a corps of literacy volunteers at the State and local level.

In the future, increased cooperation among government, organizations, institutions, and community groups will be essential to meet the educational needs of the elderly. Greater emphasis in promoting lifelong learning and expanding educational opportunities designed to foster independence among older adults are necessary components towards achieving the goal of an age integrated society.

# Chapter 17

# OLDER AMERICANS ACT

## OVERVIEW

Congressional passage of the Older Americans Act in 1965 created the first Federal program specifically designed to meet the social service needs of older people. While older persons may receive services under a number of other Federal programs, the act is the major vehicle for targeting delivery of services to senior citizens. States and area agencies on aging constitute the administrative structure for the program. In addition to funding specific services, they have broad responsibilities to act as advocates on behalf of older persons and to plan for the effective development of a service system to meet their needs. This service system is to encompass not only the services funded by the act but also services supported by other Federal, State, and local programs.

The act also supports subsidized part-time employment for low-income older persons who work in community service activities. In addition to providing employment opportunities, this program encourages local sponsors to work within their communities to break down barriers to employing older persons in both the public and private sectors.

Finally, the act supports training, research, and demonstration projects in the field of aging, and provides grants to Indian tribal organizations.

The act has developed from a program of small grants in 1966 to one which supports 662 area agencies on aging, over 8,600 service providers, over 13,000 congregate nutrition sites, over 6,000 home-delivered nutrition providers, over 54,200 community service jobs, and 83 Indian tribal organizations. Appropriations have increased from $6.5 million in fiscal year 1966 to over $1 billion in fiscal year 1983 for all titles of the act.

In 1981, the act was reauthorized (Public Law 97-115) for 3 years, through 1984. Modifications in the 1981 amendments give States and area agencies on aging more flexibility in the administration of the grant programs for supportive, senior center, and nutrition services, and consolidated the authorization for certain training, research, and demonstration activities. These amendments also emphasize transition of participants to private sector employment under the community service employment program, and eliminated an age definition for older Indians under the program of grants to tribal organizations.

## A. HISTORY

The Older Americans Act of 1965 set out a declaration of objectives aimed at improving the lives of older Americans in the areas of income, health, housing, restorative services, employment, retirement, cultural and recreational opportunities, community services, and gerontological research. In the 18 years since its enactment, the act has succeeded in creating a comprehensive system for providing needed services in the community to help older persons remain self-sufficient and independent.

The Older Americans Act was first enacted in the 89th Congress (Public Law 89-73) and has been amended nine times. The original act established the Administration on Aging (AoA) as the Federal agency responsible for the administration of programs under the act, and authorized State and community social service programs, research, demonstration, and training projects. Provisions of the original legislation were extended by the 1967 amendments. The 1969 amendments strengthened the title III community services programs and charged State agencies on aging with statewide responsibilities for planning, coordination, and evaluation of programs for older persons. Areawide model projects that would test new approaches in meeting the social service needs of the elderly were also included in these amendments.

Major amendments to the act occurred in 1972 and 1973. The 1972 amendments created the national nutrition programs and authorized grants to public and nonprofit sponsors for the development of congregate meal services. In addition to meeting the nutritional and social service needs of persons 60 years of age and over, Congress envisioned that the program would serve as an important vehicle for fostering social interaction among participants.

With the enactment of the 1973 amendments, the Older Americans Act was significantly revised and expanded by the creation of area agencies on aging. These organizations were given major responsibility for planning, coordinating, and advocating for programs that would benefit older persons. Area agencies were designated by the State unit on aging to operate within a defined planning and service area, and were primarily charged with utilizing their limited service funds as catalysts for garnering other services dollars for older persons. The 1973 amendments created a National Information and Resource Clearinghouse for the Aging and a Federal Council on Aging, and authorized grants for multipurpose senior centers, and a community services employment programs for older persons.

Amendments to the act in 1974, 1975, and 1977, made several minor adjustments to the act and extended the authority for continued program operation.

Amendments made in 1978 further strengthened and expanded title III of the act by consolidating the social services, multipurpose senior center, and nutrition services portion—all previously authorized under separate titles and separate administrative authorities. These amendments required that area agencies on aging expend at least 50 percent of their social service allotments on certain designated priority services, including access, in-home, and legal services. In addition, a separate authorization for home-delivered meals under title III was made. Previous requirements that State and area agencies develop annual plans on aging services were altered to allow 3-year planning cycles. These amendments also mandated that each State unit on aging establish a statewide nursing home ombudsman program, and added a new title VI to the act which authorized grants for social and nutritional services to Indian tribal organizations. The community service employment program (title V) was amended to raise the income eligibility requirements for participants from the Office of Management and Budget poverty level to 125 percent of the poverty level, and to increase the proportion of funding to States under the program.

The 1981 amendments to the act essentially provided for a simple 3-year extension for older Americans programs through 1984. Minor changes under the 1981 amendments provided greater flexibility to States and area agencies on aging. These changes included the following: Modified planning requirements to allow States to choose between 2-, 3-, or 4-year planning cycles; provisions to allow States the option to transfer up to 20 percent of the funds appropriated for any fiscal year between the social service and nutrition program; elimination of the requirement that 50 percent of the funds under the social services title (title III-B) be spent on certain designated priority services (access, in-home, and legal); and the inclusion of a fixed authorization ceiling for the Department of Agriculture's commodities program. In addition, the amendments provided for special emphasis in projects related to long-term care, housing, rural transportation, and mental health under title IV, and provided for funds to demonstrate methods of training and placement of older persons in private work settings under the title V program.

During fiscal year 1983, Congress began to examine a series of issues surrounding the upcoming reauthorization of the act for 1984. More specific discussion of these issues is included in this chapter.

## B. THE CURRENT FRAMEWORK

The Older Americans Act as amended in 1981 contains six titles: I—Declaration of Objectives: Definitions; II—Administration on Aging; III—Grants for State and Community Programs on Aging; IV—Training, Research, and Discretionary Projects and Programs; V—Community Service Employment for Older Americans; and VI—Grants for Indian Tribes. The major provisions of the act are described below.

### 1. Title I—Declaration of Objectives

The Older Americans Act is directed toward assisting older persons to attain full participation in the benefits of this Nation. In keeping with this goal, the act outlines 10 objectives which the governments of the United States, States, and political subdivisions are directed to secure for older persons. These objectives are: (1) An adequate income in retirement; (2) the best possible physical and mental health; (3) suitable housing designed and located to meet special needs; (4) full restorative services for those who require institutional care; (5) opportunity for employment without age discrimination; (6) retirement in health, honor, and dignity; (7) pursuit of civic, cultural, education and training, and recreational opportunities; (8) efficient community services; (9) benefits from research designed to sustain and improve health and happiness; and (10) freedom to plan and manage their lives.

### 2. TITLE II—THE ADMINISTRATION ON AGING

The Administration on Aging is established within the Office of the Secretary of Health and Human Services as the principal agency for carrying out the purposes of the Older Americans Act and administering most of the grant programs authorized under the act. The agency is directed by a U.S. Commissioner on Aging who is appointed by the President and confirmed by the Senate, and who is responsible directly to the Office of the Secretary. From an organizational perspective, the Administration on Aging is located within the Office of Human Development Services. Congress intended that the Administration on Aging have high visibility in the executive branch of Government, and serve as an effective advocate on all Federal activities and matters related to the field of aging.

Since the conception of the Administration on Aging in 1962, its appropriate placement within the Federal framework has been questioned. The original sponsors conceived of placing such an agency at the White House level so it would not be subordinate to any one agency or department, but an independent agency able to carry out its interdepartmental functions. This placement, however, was strongly opposed by officials of the executive branch, therefore, the sponsors turned to a compromise position to expedite passage of the act. The Administration on Aging was placed within the Department of Health, Education, and Welfare in 1965 and did not have independent status.

Over the years, many policymakers have questioned whether the Administration on Aging can carry out its interdepartmental functions and serve as a Federal coordinator, spokesman, and advocate for the elderly as well as impact on Federal programs and policies when it is placed within a Federal department.

During consideration of the 1978 amendments, discussion continued about the appropriate placement of the Administration on Aging. Sentiment ranged from placing the Administration as an independent office at the White House level to retaining the agency in its current position. The amendments, however, did not change prior law and retained the agency within the Office of Human Development Services (OHDS) where it currently is located.

During debate on the 1981 amendments, the House receded from its initial position that would have required that the Commissioner on Aging be directly responsible to the Secretary of Health and Human Services rather than to the Office of the Secretary.

Title II of the act is primarily structural, in that it is the part of the act which discusses the establishment of the functional units necessary to implement the act. Under the 1981 amendments, the functional units which are continued include the Administration on Aging and the Federal Council on Aging. The National Information and Resource Clearinghouse for Aging, a component of AoA was deleted from the act in 1981.

This title also requires the Secretary of HHS to conduct evaluation activities on all programs authorized by the act, including their effectiveness in achieving goals. The Secretary is authorized to use up to 1 percent of funds appropriated under the act, or $1 million, whichever is greater, to conduct evaluation activities as required under title II.

Finally, title II establishes the Federal Council on Aging, an advisory group to the President, composed of 15 members appointed by the President and confirmed by the Senate. Membership must be representative of rural and urban older Americans, national organizations with an interest in aging, business and labor, and the general public. At least five members must be older persons.

Functions of the Council include: Advising and assisting the President on matters relating to the special needs of older Americans; reviewing and evaluating Federal policies, programs, and other activities affecting the elderly; making recommendations to the President, the Secretary of HHS, and Congress on Federal policies and activities regarding the aging; and providing public forums for discussions on the problems and needs of the elderly. In addition, the Council is required to submit interim reports as it deems advisable, and an annual report by March 31 of each year to the President who then transmits it to Congress with comments and recommendation.

### 3. TITLE III—GRANTS FOR STATE AND COMMUNITY PROGRAMS ON AGING

Title III authorizes grants to State agencies on aging for developing comprehensive and coordinated delivery system of supportive social services and senior centers, congregate nutrition services, and home-delivered nutrition services. To qualify for funds, the State agency must divide the State into separate geographic areas, known as planning and service areas (PSA's), and establish area agencies on aging for developing a comparable delivery system within the PSA's. As part of the mandated delivery system, area agencies on aging coordinate existing resources and foster the expansion and development of community services for the elderly.

The title III organizational structure is intended to form a "network on aging" linking the Administration on Aging, State and area agencies on aging, other public and private agencies, and local service providers. This network is intended to help older persons in need of supportive care remain independently in their homes. It is also intended to provide a continuum of services as well as social and economic opportunities for older persons.

Title III funds are distributed to the States according to a congressionally mandated formula based on the population of older people in each State. In turn, States allocate service funds to area agencies using an intrastate funding formula which must be approved by AoA. Through a structured planning process, State and area agencies are directed to provide greater leadership in identifying gaps and weaknesses in the delivery of services as well as fostering the expansion of services for the elderly.

Title III–B, supportive services and senior centers, funds are used in accordance with a State-approved area plan. The act requires the development of a number of specified services if not otherwise available in the community. As a basis for mandated services, the 1978 amendments required that States spend at least 50 percent of their funds for social services on three categories; access service (transportation, outreach, and information and referral); in-home services (homemaker, home health aide, visiting services, telephone assurance, and chore maintenance); and legal services. It required that some funds be expended in each category of service, but the percentage of funds targeted for a specific category was a matter of local determination. The 1981 amendments modified the requirement mandating a 50-percent targeting of funds and simply required area agencies to expend "an adequate proportion" for such services.

In addition to the priority services, other allowable services under the act include: Ombudsman services; counseling and service management; health screening and other health-related services; recreational and educational-related activities; services to encourage the employment of older workers, including job counseling, job development and placement; crime prevention and victim assistance programs; and, a variety of voluntary service opportunities.

For fiscal year 1983, $240.9 million was available to support activities under title III–B—supportive services and senior centers. Additionally, $21.7 million was allocated to maintain State agency administrative activities.

Under title III–C, grants are awarded through State and area agencies on aging to public and private sponsors for establishing and operating both congregate and home-delivered meal projects for persons age 60 and older and their spouses of any age. Additionally, the 1981 amendments allow congregate nutrition services to persons under 60 years if those individuals are handicapped or disabled or if they reside in a housing facility which is occupied primarily by the elderly at which congregate nutrition services are provided. Participants in these programs may pay for meals based on what they feel they can afford. Income derived from these donations is used by project sponsors to increase the number of meals served.

The 1981 amendments continue to provide for separate authorizations for congregate and home-delivered meals. The financial support for congregate nutrition was $321.6 million for fiscal year 1983; for home-delivered nutrition the level was $62 million for the same fiscal year.

During the 1981 reauthorization, considerable debate was focused on the issue of total consolidation of the separate authorizations for programs under title III. It was argued that this consolidation would provide greater flexibility to States and area agencies on aging to select the appropriate mix of services for meeting the needs of their constituencies. Appropriations for part B (supportive services) and part C (nutrition) have grown unevenly over the past few years, with most increases going to the part C. Although the conference agreement on this issue retained separate funding authorizations for parts B and C, the new amendments permit States to transfer up to 20 percent of their moneys between social services and nutrition allotments.

Nutrition services evolved from nutrition demonstration projects first funded under the Older Americans Act Amendments of 1968, to develop techniques for improving diets, fostering social interaction, and facilitating the delivery of social services for the elderly. The meals are intended to improve the health of program participants, and to attract isolated older persons to a place where services and opportunities are available.

Congregate nutrition services are available at least once each day, 5 days per week, along with outreach, transportation, counseling, recreation, nutrition education, information and referral, and other support services. In many cases, congregate "meals sites" have evolved into senior centers which act as community focal points for the needs of older persons.

Home-delivered nutrition programs are provided on a determination of need basis. Home-delivered meals are served at least once per day to individuals homebound by reason of illness, an incapacitating disability, or an extreme transportation problem.

Under the 1981 amendments, the U.S. Department of Agriculture receives continued authority to provide surplus commodities or cash in lieu of commodities to supplement the cost of providing meals under title III. The USDA reimbursement had been provided on a per meal basis in an amount adjusted for inflation to reflect changes in the Consumer Price Index for food away from home. Under the amended act, specific authorizations for the commodities program were capped at $93.2 million, $100 million and $105 million, for fiscal years 1982, 1983, and 1984, respectively. Further, provisions were included that in any fiscal year in which the per meal reimbursement authorized exceeds the authorization for the commodities program for that fiscal year, the Secretary shall reduce the per meal reimbursement, or provide for such sums as may be necessary to maintain the level of reimbursement for the number of meals served under this program in fiscal year 1981.

### 4. Title IV—Training, Research, and Discretionary Projects and Programs

Title IV of the Older Americans Act is authorized to support efforts in training, education, research, demonstrations, and evaluation which adds knowledge to improve program effectiveness and efficiency. The major activities undertaken in each of the title IV program areas are designed to develop and disseminate information to assist decisionmakers and service providers in addressing issues concerning older persons. The 1981 amendments to the act consolidated the Commissioner's authority to support a number of training, research, and demonstration activities, simplified certain funding requirements, and granted greater flexibility to the Commissioner in the award of discretionary funds.

Under the 1981 amendments, title IV includes: Part A—education and training, which provides grants to train and recruit personnel for the field of aging and establish multidisciplinary centers of gerontology; and B—research, demonstrations, and other activities, which provides grant funds to support projects in long-term care, legal services, national impact activities, utility and home heating cost demonstration projects, rural transportation, mental health, housing needs of the elderly, and special needs of minority individuals.

During fiscal year 1983, the Office of Human Development Services (OHDS) continued the coordinated discretionary funds program. According to OHDS the major purpose of this initiative is to better focus discretionary resources on priority issues requiring the involvement of more than one program office under OHDS. Examples of these issues include: Services to multiproblem developmentally disabled clients; intergenerational solutions to problems of children, youth, and the aged; and cost savings through joint problem solving on common service delivery management concerns.

As a result of the coordinated approach, OHDS reported that client populations of concern to more than one OHDS program received increased attention and funding than would have been possible under separate, uncoordinated programs. A total of approximately 180 grants were awarded by the close of fiscal year 1983 under the coordinated program. During fiscal year 1983 OHDS obligated over $21.5 million for the coordinated program. Of this amount, approximately $4.5 million was contributed by the Administration on Aging.

In addition to the coordinated discretionary program, the Commissioner of AoA is required to carry out model projects which will demonstrate methods of improving or expanding supportive, nutrition, or other services that promote the well-being of older persons. The 1981 amendments to the act required the Commissioner to give special consideration to projects relating to the special needs of the rural elderly, including alternative health care delivery systems, advocacy, outreach programs, and transportation services. Title IV also specifies other model projects to receive special emphasis including those designed to: Meet special health care (including mental health) and housing needs of older persons; provide education and training and preretirement education information; coordinate supportive services for the homebound elderly; and meet the special needs of older individuals not receiving adequate services under other portions of the act. Finally, provisions under this part, required that special demonstrations relating to legal services needs of the elderly and issues relating to developing comprehensive long-term care systems be carried out.

Appropriations for title IV reached their height in fiscal year 1980 at a level $54.3 million. The fiscal year 1984 budget proposed a level of $5 million, a decrease of 77 percent from the 1983 level. During fiscal year 1983, these programs operated under a continuing resolution at a level of $22.2 million.

### 5. TITLE V—SENIOR COMMUNITY SERVICE EMPLOYMENT PROGRAM

The senior community service employment program (SCSEP) was established within the Department of Labor for creating part-time public service employment positions for persons age 55 and older with incomes of not more than 125 percent of the poverty level. The program is geared to creating employment positions that contribute to the general welfare of the community, such as aides in hospitals, schools, libraries, social service agencies, etc. Program participants are paid at least the Federal minimum wage, the State or local minimum wage, or the prevailing wage in the community for similar occupations, whichever is highest. Additionally, project sponsors are required to provide training opportunities for participants when necessary to maximize their skills and talents.

The Department of Labor administers the title V community service employment program for older Americans. The program is modeled after the operation mainstream program which was first funded in 1965 under the Economic Opportunity Act. Operation mainstream authorized jobs for poor and chronically unemployed individuals, primarily in rural areas. The Department of Labor enters into contractual agreements with organizations that sponsor employment projects for older workers. Under the 1973 amendments, funds were apportioned to the States based on the States' elderly population. The 1975 amendments revised the formula to allocate funds more equitably to States with lower per capita income. The 1978 amendments fostered intrastate coordination between national contractors and State agencies on aging and increased the proportion of funding to State governments so that States could take a more active role in creating public service employment for older workers. Employment programs are located in universities, private nonprofit agencies, city and county governments, and Indian tribal organizations.

The SCSEP program is managed by State agencies on aging and the following national contractors: (1) Green Thumb, Inc., Washington, D.C., an agency of the National Farmers' Union. (2) National Council on Aging, Washington, D.C. (3) National Council of Senior Citizens, Washington, D.C. (4) National Retired Teachers Association/American Association of Retired Persons in Washington, D.C. (5) U.S. Department of Agriculture, Forest Service, Washington, D.C. (6) National Center of Black Aged, Washington, D.C. (7) National Association for Spanish Speaking Elderly, Los Angeles, Calif. (8) National Urban League, New York, N.Y. Under the program, the Federal share of project costs may be up to 90 percent (100 percent in disaster or economically depressed areas). The Secretary of Labor must reserve from the annual appropriation funds sufficient to maintain the national contractor's fiscal year 1978 level of activity. The remaining dollar amount that exceed the 1978 level are apportioned so that State governments receive 55 percent and national contractors receive 45 percent of the dollar amount. Under the 1981 amendments, the 45 percent of excess funds which go to the national contractors within States must be distributed in an equitable manner among the various States.

TABLE 1.—SENIOR COMMUNITY SERVICE EMPLOYMENT PROGRAM DISTRIBUTION OF FUNDS, PROGRAM YEAR 1982-83—JULY 1, 1983 TO JUNE 30, 1984

| State | Green Thumb | NCOA | NCSC | AARP | Forest Service | NCBA | ANNPM | Urban League | Total, national sponsors | State governments [1] | Grand total |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Alabama | $720,869 | $352,761 | $3,554,015 | 0 | $449,898 | $797,546 | 0 | 0 | $5,375,079 | 0 | $5,875,079 |
| Alaska | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | $1,368,609 | 1,368,609 |
| Arizona | 153,408 | 1,631,233 | 0 | 0 | 577,835 | 0 | $332,383 | 0 | 2,694,859 | 685,968 | 3,380,827 |
| Arkansas | 2,945,265 | 0 | 0 | $84,809 | 460,198 | 357,931 | 0 | 0 | 4,612,203 | 1,174,022 | 5,786,225 |
| California | 2,278,403 | 4,538,362 | 5,141,433 | 3,357,775 | 2,611,603 | 0 | 1,988,089 | 0 | 19,916,665 | 5,069,727 | 24,986,392 |
| Colorado | 562,332 | 0 | 904,842 | 347,623 | 511,210 | 0 | 0 | 0 | 2,326,007 | 529,078 | 2,918,085 |
| Connecticut | 322,460 | 0 | 2,226,512 | 0 | 0 | 0 | 0 | 358,289 | 2,907,261 | 740,034 | 3,647,295 |
| Delaware | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1,368,609 | 1,368,609 |
| District of Columbia | 0 | 15,355 | 563,017 | 15,355 | 51,183 | 788,223 | 0 | 0 | 1,433,133 | 364,800 | 1,797,933 |
| Florida | 4,359,198 | 1,103,672 | 2,759,598 | 6,377,121 | 679,836 | 582,639 | 1,395,440 | 0 | 17,257,504 | 0 | 17,257,504 |
| Georgia | 1,283,202 | 562,374 | 0 | 1,978,565 | 547,035 | 567,486 | 0 | 511,249 | 5,449,911 | 1,387,259 | 6,837,170 |
| Hawaii | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1,368,609 | 1,368,609 |
| Idaho | 360,412 | 0 | 0 | 326,792 | 597,416 | 0 | 0 | 0 | 1,184,620 | 301,542 | 1,486,162 |
| Illinois | 4,104,495 | 0 | 2,509,722 | 1,165,411 | 373,136 | 879,169 | 874,058 | 357,802 | 10,263,793 | 2,612,618 | 12,876,411 |
| Indiana | 3,389,279 | 0 | 1,840,333 | 961,063 | 153,361 | 0 | 0 | 311,834 | 6,655,870 | 1,694,232 | 8,350,102 |
| Iowa | 1,646,723 | 0 | 629,028 | 1,048,379 | 0 | 0 | 0 | 0 | 3,324,130 | 846,147 | 4,170,277 |
| Kansas | 2,472,941 | 0 | 0 | 0 | 0 | 0 | 778,538 | 0 | 3,251,479 | 0 | 3,251,479 |
| Kentucky | 2,524,520 | 950,528 | 0 | 807,438 | 536,587 | 0 | 0 | 0 | 4,819,073 | 1,226,681 | 6,045,754 |
| Louisiana | 1,155,432 | 511,253 | 802,668 | 644,179 | 465,240 | 0 | 547,041 | 0 | 4,125,813 | 1,050,214 | 5,176,027 |
| Maine | 204,590 | 966,677 | 0 | 373,387 | 46,033 | 0 | 0 | 0 | 1,590,687 | 404,904 | 1,995,591 |
| Maryland | 976,036 | 0 | 2,478,416 | 0 | 0 | 0 | 0 | 0 | 3,454,452 | 879,321 | 4,333,773 |
| Massachusetts | 1,083,808 | 0 | 4,008,044 | 654,375 | 0 | 0 | 0 | 454,995 | 6,201,222 | 1,578,502 | 7,779,724 |
| Michigan | 3,158,089 | 0 | 2,391,563 | 1,093,578 | 567,230 | 0 | 332,161 | 725,645 | 8,268,266 | 2,104,663 | 10,372,929 |
| Minnesota | 3,599,016 | 0 | 976,437 | 0 | 710,601 | 0 | 0 | 720,826 | 6,006,880 | 1,529,033 | 7,535,913 |
| Mississippi | 735,394 | 0 | 949,885 | 0 | 796,677 | 704,753 | 0 | 0 | 3,186,709 | 811,167 | 3,997,876 |
| Missouri | 3,313,203 | 593,104 | 654,460 | 1,186,209 | 628,895 | 0 | 0 | 0 | 6,375,871 | 1,622,959 | 7,998,830 |
| Montana | 1,384,834 | 0 | 0 | 280,659 | 280,659 | 0 | 0 | 0 | 1,946,152 | 0 | 1,946,152 |
| Nebraska | 1,664,250 | 0 | 0 | 500,295 | 51,051 | 0 | 0 | 0 | 2,215,596 | 250,149 | 2,465,745 |
| Nevada | 280,837 | 0 | 0 | 719,963 | 183,820 | 0 | 0 | 0 | 1,184,620 | 301,542 | 1,486,162 |
| New Hampshire | 424,621 | 0 | 0 | 816,036 | 184,173 | 0 | 0 | 0 | 1,424,830 | 0 | 1,424,830 |
| New Jersey | 3,603,186 | 3,808,007 | 1,328,835 | 0 | 0 | 0 | 0 | 884,186 | 9,624,214 | 0 | 9,624,214 |
| New Mexico | 0 | 0 | 0 | 449,389 | 781,324 | 0 | 0 | 0 | 1,230,713 | 313,274 | 1,543,987 |
| New York | 5,468,513 | 4,466,804 | 4,216,377 | 2,652,485 | 0 | 0 | 0 | 1,620,111 | 18,424,290 | 4,689,848 | 23,114,138 |
| North Carolina | 1,017,207 | 649,177 | 1,645,944 | 0 | 1,603,617 | 1,124,558 | 0 | 306,698 | 6,374,201 | 1,622,534 | 7,996,735 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| North Dakota | 1,635,951 | 0 | 0 | 238,647 | 0 | 0 | 0 | 0 | 1,874,598 | 0 | 1,874,598 |
| Ohio | 2,796,103 | 1,553,958 | 2,448,507 | 2,612,081 | 148,240 | 521,394 | 0 | 1,053,011 | 11,133,294 | 2,833,947 | 13,967,241 |
| Oklahoma | 2,499,813 | 0 | 0 | 654,348 | 102,242 | 0 | 582,779 | 0 | 3,839,182 | 977,252 | 4,816,434 |
| Oregon | 1,620,575 | 511,222 | 0 | 603,242 | 817,956 | 0 | 0 | 0 | 3,552,995 | 904,404 | 4,457,399 |
| Pennsylvania | 5,034,538 | 2,514,714 | 2,714,051 | 1,610,030 | 398,674 | 771,792 | 398,674 | 868,905 | 14,311,378 | 3,642,918 | 17,954,296 |
| Rhode Island | 0 | 0 | 530,884 | 796,326 | 0 | 0 | 0 | 0 | 1,327,210 | 337,837 | 1,665,047 |
| South Carolina | 1,022,123 | 255,533 | 664,385 | 781,938 | 500,844 | 0 | 0 | 0 | 3,224,823 | 820,869 | 4,045,692 |
| South Dakota | 1,864,379 | 0 | 0 | 194,216 | 102,219 | 0 | 0 | 0 | 2,160,814 | 0 | 2,160,814 |
| Tennessee | 1,655,601 | 643,846 | 1,435,878 | 0 | 710,276 | 746,043 | 0 | 0 | 5,191,644 | 1,321,517 | 6,513,161 |
| Texas | 4,865,054 | 1,947,044 | 1,359,354 | 2,892,459 | 413,938 | 0 | 802,325 | 393,497 | 12,673,671 | 3,226,046 | 15,899,717 |
| Utah | 843,633 | 0 | 0 | 0 | 685,133 | 0 | 0 | 0 | 1,528,766 | 389,143 | 1,917,909 |
| Vermont | 173,546 | 1,051,484 | 0 | 0 | 142,920 | 0 | 0 | 0 | 1,367,950 | 348,207 | 1,716,157 |
| Virginia | 2,356,296 | 674,688 | 0 | 955,807 | 582,685 | 0 | 0 | 741,134 | 5,310,610 | 1,351,800 | 6,662,410 |
| Washington | 634,117 | 0 | 654,573 | 1,436,992 | 782,419 | 0 | 0 | 0 | 3,508,101 | 892,977 | 4,401,078 |
| West Virginia | 321,953 | 1,425,796 | 720,563 | 0 | 408,832 | 0 | 0 | 0 | 2,877,144 | 732,368 | 3,609,512 |
| Wisconsin | 3,444,189 | 0 | 2,023,589 | 0 | 720,520 | 0 | 0 | 306,604 | 6,494,902 | 1,653,258 | 1,149,160 |
| Wyoming | 633,159 | 0 | 0 | 219,563 | 331,898 | 0 | 0 | 0 | 1,184,620 | 301,542 | 1,486,162 |
| American Samoa | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 686,860 | 686,860 |
| Guam | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 686,860 | 686,860 |
| Puerto Rico | 2,006,375 | 0 | 0 | 1,462,067 | 373,183 | 0 | 0 | 0 | 3,841,625 | 0 | 3,841,625 |
| Trust Territories | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 453,328 | 453,328 |
| Northern Marianas | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 233,532 | 233,532 |
| Virgin Islands | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 686,860 | 686,860 |
| Total | 88,500,918 | 30,727,592 | 52,132,913 | 41,062,602 | 21,097,597 | 7,841,534 | 8,031,488 | 9,614,786 | 259,009,430 | 60,440,570 | 309,450,000 |

---

[1] The following State sponsors relinquish their funding to the national sponsors to carry out the program: Alabama, Florida, Kansas, Montana, South Dakota, North Dakota, New Hampshire, New Jersey, and Puerto Rico. Arizona and Nebraska provide a partial turnover.

## TABLE 2.—SENIOR COMMUNITY SERVICES EMPLOYMENT PROGRAM DISTRIBUTION OF POSITIONS, PROGRAM YEAR 1982–83—JULY 1, 1983 TO JUNE 30, 1984

| State | Total, national sponsor | State sponsor | Total, State |
|---|---|---|---|
| Alabama | 1,149 | 0 | 1,149 |
| Alaska | 0 | 268 | 268 |
| Arizona | 527 | 134 | 661 |
| Arkansas | 902 | 230 | 1,132 |
| California | 3,897 | 992 | 4,889 |
| Colorado | 455 | 116 | 571 |
| Connecticut | 569 | 145 | 714 |
| Delaware | 0 | 268 | 268 |
| District of Columbia | 280 | 71 | 352 |
| Florida | 3,377 | 0 | 3,377 |
| Georgia | 1,066 | 271 | 1,338 |
| Hawaii | 0 | 268 | 268 |
| Idaho | 232 | 59 | 291 |
| Illinois | 2,008 | 511 | 2,519 |
| Indiana | 1,302 | 331 | 1,634 |
| Iowa | 650 | 166 | 816 |
| Kansas | 636 | 0 | 636 |
| Kentucky | 943 | 240 | 1,183 |
| Louisiana | 807 | 205 | 1,013 |
| Maine | 311 | 79 | 390 |
| Maryland | 676 | 172 | 848 |
| Massachusetts | 1,213 | 309 | 1,522 |
| Michigan | 1,618 | 412 | 2,030 |
| Minnesota | 1,175 | 299 | 1,474 |
| Mississippi | 624 | 159 | 782 |
| Missouri | 1,247 | 318 | 1,565 |
| Montana | 381 | 0 | 381 |
| Nebraska | 433 | 49 | 482 |
| Nevada | 232 | 59 | 291 |
| New Hampshire | 279 | 0 | 279 |
| New Jersey | 1,883 | 0 | 1,883 |
| New Mexico | 241 | 61 | 302 |
| New York | 3,605 | 918 | 4,522 |
| North Carolina | 1,247 | 317 | 1,565 |
| North Dakota | 367 | 0 | 367 |
| Ohio | 2,178 | 554 | 2,733 |
| Oklahoma | 751 | 191 | 942 |
| Oregon | 695 | 177 | 872 |
| Pennsylvania | 2,800 | 713 | 3,513 |
| Rhode Island | 260 | 66 | 328 |
| South Carolina | 631 | 161 | 792 |
| South Dakota | 423 | 0 | 423 |
| Tennessee | 1,016 | 259 | 1,274 |
| Texas | 2,480 | 631 | 3,111 |
| Utah | 299 | 76 | 375 |
| Vermont | 268 | 68 | 336 |
| Virginia | 1,039 | 264 | 1,304 |
| Washington | 686 | 175 | 861 |
| West Virginia | 563 | 143 | 706 |
| Wisconsin | 1,271 | 323 | 1,594 |
| Wyoming | 232 | 59 | 291 |
| American Samoa | 0 | 134 | 134 |
| Guam | 0 | 134 | 134 |
| Puerto Rico | 752 | 0 | 752 |
| Trust Territories | 0 | 89 | 89 |
| Northern Marianas | 0 | 46 | 46 |
| Virgin Islands | 0 | 134 | 134 |
| Total | 50,677 | 11,826 | 62,502 |

Although persons 55 years or older are eligible for the program, priority is to be given to placing persons 60 years or older in community service jobs. Their income levels must not exceed 125 percent of the poverty level guidelines issued by the Department of Health and Human Services (in 1983, $6,075 for a one-person household). Enrollees are paid no less than the Federal or State minimum wage or the local prevailing rate of pay for similar employment, whichever is higher. Participants may work up to 1,300 hours per year and average 20 to 25 hours per week. For the 1981-82 program year the average hourly wage paid to enrollees was $3.46. In addition to wages, enrollees receive annual physical examinations, personal and job-related counseling, and some job training.

During the 1981-82 program year, 67 percent of those enrolled were female, 56 percent had less than a high school education, and 33 percent were minority group members. A majority, 52 percent were 65 years of age or older; over one-fourth were 70 years or older. Eighty-five percent had family incomes below the poverty level, and 11 percent were veterans.

Participants work in a wide variety of community service activities. During the 1981-82 program year, over 53 percent of job placements were in services to the general community while over 47 percent were in services to the elderly. The program provides substantial support to nutrition services to the elderly, primarily funded under title III of the Older Americans Act and administered by State and area agencies on aging. In the 1981-82 program year, 12 percent, or 6,852, of the employment opportunities in title V aging services placements were in nutrition services. Other job areas were in recreation/senior centers with over 5,044 jobs, or 9 percent of the placements in aging services, and outreach and referral services, with 4,030, or 7.1 percent of the placements. In services to the general community, enrollees were placed primarily in education and social service activities.

Under the 1981 amendments, a new change involved the emphasis on private sector employment of older workers. Public Law 97-115 requires the Secretary of Labor to conduct experimental projects designed to assure second-career training and placement of eligible individuals in employment opportunities with private business concerns. The Secretary is required to issue criteria designed to assure that these experimental projects will involve different kinds of work modes such as flextime, job sharing, and other arrangements relating to reduced physical exertion of the elderly. Additionally, the Secretary is required to emphasize projects which involve second career and job placement in growth industries and in jobs reflecting new technological skills. The new law requires that the Secretary submit a final report to the Congress on an evaluation conducted on this project no later than February 1, 1984.

Consistent with provisions of the Older Americans Act, the title V program is "forward funded." Thus, appropriations for this program are used during the annual period which begins July 1 of the calendar year immediately following the beginning of the Federal fiscal year, and ending on June 30 of the following calendar year. For example, appropriations made available for the program for fiscal year 1982, funded the program from July 1, 1982 through June 30, 1983.

The 1981 amendments to the Older Americans Act authorize the following amounts for title V; fiscal year 1982, $277.1 million; for fiscal year 1983, $296.5 million; and for fiscal year 1984, $317.3 million. During consideration of the continuing resolution for fiscal year 1983, Congress increased funding for title V to $281.9 million. In addition, an emergency job creation supplemental passed during fiscal year 1983 provided an additional $37.5 million bringing the total for 1983 to $319.4 million.

The Reagan administration's fiscal year 1984 budget contained a proposal to incorporate funds for the program under the administrative jurisdiction of the Administration on Aging, to discontinue the separate funding for title V in the DOL, and to make a number of program changes. The funding request was for $277.1 million. A legislative proposal to carry out these changes was submitted by the administration for the consideration of Congress on June 28, 1983. No action was taken on this proposal. The Labor, HHS, Education, and related agencies appropriation bill for 1984, included $317.3 million for the title V program.

### 6. Title VI—Grants to Indian Tribes

Under the 1981 amendments, title VI was reauthorized to continue promoting the delivery of social and nutritional services for older Indians comparable to services provided for others under the act's title III State and community programs on aging. Grants are authorized to tribal organizations representing 75 or more Indians age 60 and older for paying all of the costs of services. To qualify for funds, tribal organizations are required to submit to the Commissioner on Aging a plan which provides for:

—Evaluating the need for social and nutritional services among older Indians represented by the tribal organization.
—Social services, nutritional services, legal services, and nursing home ombudsman services consistent with requirements set forth under title III of the act.
—Information and referral services.
—Periodic evaluation of activities and projects carried out under such a plan.
—Employment of older Indians for full- or part-time staff positions whenever feasible.

Tribal organizations have the option of receiving services under the title III network of State and area agencies on aging or applying for funding directly to the Commissioner on Aging.

From a historical perspective, it was recognized that older Indians generally have not received services and benefits equivalent to those provided other persons under title III program of grants for State and community programs. With the passage of the 1975 amendments, the Commissioner was authorized to allow Indian tribes to bypass the traditional title III State and area agency funding mechanism and apply directly to the Commissioner for funds necessary to establish a social services program.

This authority however, was never exercised. Congress felt the title's shortcomings were related to the cumbersome determination process which required complicated grant applications and judgments by many levels of government before a decision could be rendered. Moreover, the authority provided in this title failed to recognize "tribal sovereign status." Representatives of Indian groups testified that tribal organizations, not the Commissioner, should determine the best funding source for establishing a social services program.

The 1978 amendments, therefore, revised the 1975 law to provide a separate title and funding authority for social and nutritional services for federally recognized tribal organizations.

The 1981 amendments relaxed a number of provisions contained in prior law, including elimination of the requirement that Indians be 60 years and over in order to participate under the program. This change was made to provide flexibility to tribal organizations and was based on statistics presented to the House Committee on Education and Labor indicating that the lifespan of Indians was considerably shorter than that of other Americans. The amendments also eliminated the prior law requirement that the State's allotment under title III be reduced by the amount attributable to Indians being served under title VI in the State.

Other provisions allowing for more flexibility in the administration of the program added by the 1981 amendments include: Making legal and ombudsman services to older Indians an allowable rather than a required service; allowing funds that would otherwise be expended for nutritional services under title VI to be used for social services when the need for nutritional services is being met from other sources; and removing a prior law provisions requiring that tribal organizations select only nonprofit private organizations to conduct project evaluations, giving authority to tribes to select an organization to carry out these activities.

## C. MAJOR DEVELOPMENTS UNDER THE OLDER AMERICANS ACT DURING 1983

### 1. The 1984 Reauthorization of the OAA: Selected Issues of Concern

Authorization of appropriations for the Older Americans Act programs expire at the end of fiscal year 1984. As a result of this fact, a series of issues on the various titles of the act were examined during the first session of the 98th Congress. In addition to meetings and discussions conducted by the Federal Council on Aging and the national aging organizations, a number of congressional committee hearings were held in Washington and throughout the country to review items of concern. At present, committees considering amendments on the act are the House Committee on Education and Labor (Subcommittee on Human Resources) and the Senate Committee on Labor and Human Resources (Subcommittee on Aging). Besides these two legislative committees, both the Senate Special Committee on Aging and the House Select Committee on Aging have been involved in examining various provisions under the act.

The OAA has been amended nine times since its inception in 1965 with significant amendments in the structure of the programs in 1973 that created authority for area agencies, and in 1978, when efforts were made to strengthen the State and local programs for supportive, nutrition, and senior center services. The most recent amendments to the act occurred in 1981 with the passage of Public Law 97-115.

Although a host of issues have been raised, it is the general perception that no major restructuring of the act will occur during the 1984 reauthorization process. Rather, it is likely that Congress will take steps to further define and fine tune provisions under the various titles. Presented below are some of the major items of concern that have been articulated during the past year.

### (A) ORGANIZATIONAL STATUS OF AOA

Changes in the organizational status of the AoA has frequently been an issue in consideration of the reauthorization of the Older Americans Act. Currently, AoA is located within the Office of the Assistant Secretary for Human Development Services (OHDS). The organizational status and its effect on the ability of the agency to carry out its broad advocacy, planning, and coordination activities for aging programs have been debated since the inception of the act in 1965.

Changing the current structure was most recently considered by Congress during the 1981 reauthorization process. Many observers, including representatives of national aging organizations, believed that because of the magnitude of issues in the field of aging and because the goals of the Older Americans Act intersect with many other Federal programs, AoA's organizational status should be elevated to allow greater visibility and leverage for aging programs and policy. Others felt that it would be infeasible to raise the status of one organization responsible for one human service group as compared with other groups, and that organizational status alone does not necessarily affect ability to be an advocate. Further, some observers felt that upgrading the position would not accomplish the objective of more effective aging policies unless significant authority were attached to the position, and sufficient staff to support the position were added. Although the issue was extensively reviewed in 1981, no change was made in final passage of the legislation.

This issue has again surfaced during discussions on the 1984 reauthorization. Both the National Association of Area Agencies on Aging and the National Association of State Units on Aging have recommended that the Commissioner on Aging be elevated to the level of an Assistant Secretary within HHS. Other national aging organizations have supported this position. In preparing recommendations on the act, the Federal Council on Aging did not support this position, but urged the Secretary of HHS and the Assistant Secretary of OHDS to provide the maximum support possible to the Commissioner on Aging to carry out the mandates under the act. It is expected that this issue will be extensively discussed during 1984.

### (B) TARGETING OF SERVICES UNDER THE ACT

Another issue under discussion is whether, and if so to what extent, the act should be amended to more clearly focus on certain groups of older persons. Some observers have indicated that in view of the limited resources available under the act and the special needs of certain groups of older persons, the act, and its implementation, should be more concentrated on such groups.

Title III currently requires that preference in providing supportive and nutrition services be given to those older persons with the "greatest economic and social needs." Although various provisions have required that special attention be given to certain groups, allotment of title III funds to States is based solely on the number of older persons in the State. While Congress has required that priority be given to persons of low income, legislative intent, as evidenced by committee reports on various reauthorizations, has included specific prohibition on employing a means test for participation in services made available under title III, and has always maintained that the act is open to all older persons in need of services. In addition, under that statute, States are required to distribute funds according to a formula taking into account the geographical distribution of persons 60 years and over. AoA regulations require the State to include economic or social factors in the formula.

During the first session of the 98th Congress, the Senate Subcommittee on Aging held a hearing on the issue of targeting. Testimony presented by the witnesses ranged from those who indicated that the current legislation provides sufficient flexibility for State and local agencies to serve targeted groups, to those individuals who supported the concept that a specific dollar "setaside" be made to give priority to minority, Indians, and limited English-speaking individuals. One witness expressed the view that targeting be based on the concept of functional capacities of older persons. Again, it is anticipated that this issue will be extensively debated during reauthorization.

### (C) THE AGING NETWORK AND COMMUNITY-BASED LONGTERM CARE

With the growing concern of the rising cost of health care for the elderly, proposals have been made that examine the role of State and area agencies on aging in the development of community-based long-term care. During 1983 the National Association of Area Agencies on Aging, articulated a proposal that sets forth the view that area agencies should be required to coordinate and integrate all programs and funding for the elderly, and to develop a client-centered assessment system to assure the accessibility of case management services as a primary component of community-based long-term care.

The issuance of this policy statement raised some questions about the future direction of the title III program relative to the development of such a long-term care system. Although the OAA authorizes a number of services which are vital components of a long-term care system, such as home care and home-delivered meal services, it is generally not considered to be a long-term care program.

In the broader context, the policy statement reflects a growing concern among health and social service provider groups about the future direction for the organization and delivery of long-term care. Contributing to this concern are factors related to the demography of aging, predictions about the future need for both institutional and community-based services, waiting lists for nursing home beds as well as home care and other community-based services. Most important, however, is the growing concern regarding the current and future costs of such care. These factors have compelled some States to reorganize certain components of long-term care organization and delivery under their control. In some cases State and area agencies on aging have been significantly involved and been in the forefront of such action.

While this issue will require more concerted action on the part of many Federal agencies and State and local organizations in developing a responsive and coordinated approach to long-term care, it is expected that it will be an issue that will be reviewed carefully during the remainder of the 98th Congress.

### (D) DISSEMINATION OF DATA RELATED TO RESEARCH AND DEMONSTRATION ACTIVITIES

Prior to the 1981 amendments to the OAA, title II required the Commissioner on Aging to establish a National Information and Resource Clearinghouse for Aging. Because of criticism leveled at the Clearinghouse, citing its ineffectiveness for collecting and disseminating information and materials on aging, the 1981 amendments eliminated the program.

There has been recent attention on whether or not the dissemination of information emanating from research, demonstration, and training activities funded by AoA needs to be improved. The Federal Council on Aging has recommended that greater efforts be given to coordinating and analyzing findings from completed and future research and evaluation projects, and to develop and implement a system to access findings and to disseminate "best practices" concepts to agencies responsible for service delivery. A reexamination of the role of a clearinghouse under the OAA is expected to be another issue under discussion for 1984.

### (E) TRANSFER OF THE TITLE V SENIOR EMPLOYMENT PROGRAM

The community service employment program, authorized and administered by the Department of Labor (DOL) under title V, is one of two programs under the act not administered by AoA. The program, as explained before, provides subsidized part-time jobs for low-income older persons (55 and over). The law requires that a portion of funds be allocated to national organizations and a portion to State agencies on aging.

An issue for review in connection with the reauthorization of the title V program may include whether the program should continue to be administered by DOL, or whether the program should be transferred to AoA. In its 1984 budget request, the administration proposed to incorporate funds for title V under the administrative jurisdiction of AoA, to discontinue separate funding for title V in DOL, and to make a number of program changes. No subsequent congressional action was taken on this proposal, and it therefore remained under the authority of DOL at the beginning of fiscal year 1984.

In view of this proposal and the act's need for reauthorization during 1984, the Subcommittee on Aging of the Senate Committee on Labor and Human Resources requested the General Accounting Office (GAO) to conduct a review of title V, including an identification of potential problems and concerns related to the proposal to transfer the program to HHS. The GAO is expected to release a report later in 1984.

Supporters of the proposed shift of title V to HHS, such as the Federal Council on Aging, indicate that the move would consolidate authority for the administration of all OAA programs within one Federal agency. The program has been criticized for a lack of coordination of employment activities sponsored by national organizations and by State agencies. If administered by AoA, supporters of the proposal say, the Commissioner on Aging might be in a stronger position to mandate coordination by national organizations and State agency sponsored activities.

Opponents of the proposal assert that AoA does not have the capacity to administer the program and, because it is an employment program, it is more properly located in DOL. National organizations oppose the administration's proposal because it would have phased out the funding for national organizations in favor of awards to State agencies on aging. Other observers have raised concerns regarding the costs to the Federal Government necessary to effect such a transfer. It is anticipated that this will be one of the more controversial issues under discussion during the reauthorization period.

### (F) TRANSFER OF FUNDS AMONG TITLE III CATEGORIES

Finally, the issue of the transfer of funds between allotments or consolidation of authorization of appropriations is again a subject of discussion. In its policy statement on the 1984 reauthorization of the act, the National Association of State Units on Aging (NASUA) has taken the position that States should be allowed to transfer up to 25 percent of its funds between the separate allotments for supportive and nutrition services, an increase of 5 percent above the current law provision of 20 percent. The NASUA position would require States to provide assurances that additional transferred funds are targeted to community-based long-term care services for the frail elderly. The Federal Council on Aging has taken the position that the separate subcategories of title III should be consolidated with no distinction made between supportive and nutrition funding categories.

The following table presents total title III State allotments for the various title III programs and the net amount transferred among these programs for the past 2 fiscal years.

TABLE 3.—AMOUNT OF FUNDS TRANSFERRED BETWEEN TITLE III FUNDING CATEGORIES

[In millions]

| | State administration | Supportive services | Congregate nutrition services | Home-delivered nutrition services |
|---|---|---|---|---|
| Total State allotment: | | | | |
| 1982 | $21.7 | $239.9 | $283.9 | $56.8 |
| 1983 | 21.7 | 240.5 | 317.5 | 62.0 |
| Net amount transferred: | | | | |
| 1982 | +2.3 | +4.3 | −22.4 | +15.8 |
| 1983 | +2.3 | +18.2 | −38.3 | +17.9 |

Source: Administration on Aging.

The congregate nutrition program receives the greatest amount of funding of any program under the act. Reasons for transfer from this category by States to other title III programs might include: The need for additional funding for certain supportive services, such as transportation services to meal sites; a greater demand for home-delivered meals than provided through the appropriated amount; or lack of sufficient funding for State agency administration, due to State fiscal pressures.

## 2. NUTRITION SERVICE EVALUATION

During 1983 the results of a study that evaluated the impact of the nutrition services program under the OAA was published. The study was prepared for the Administration on Aging by Kirschner Associates, Inc., in conjunction with Opinion Research Corp., and drew from a nationwide survey of 3,788 persons involved in the nutrition programs. The principal purpose of the evaluation was to ascertain whether nutrition services significantly benefit older Americans.

The study found that participant population at nutrition centers is relatively stable. Two-thirds of those who were participants during 1982 have remained enrolled in the program over the past 6 years, and 90 percent indicated that they intend to continue to remain active in the nutrition program in the future. The evaluation also found some interesting data related to the age and characteristics of the participants. In 1982, 41 percent of the congregate meal and two-thirds of the home-delivered meal recipients were 75 years of age or older. This represented an increase from 1976, when only one-third of the program participants were this age or over. In addition, 75 percent of the congregate participants exhibited one or more of the priority characteristics of advanced age, low income, minority status, isolation, mobility impairment, or the limited ability to speak English.

Perhaps the most important factor that the evaluation found was that nutrition services do significantly improve the dietary intake of the participants. Although several variables were related to dietary intake, the study noted, the elderly whose dietary intake data reflected consumption of either a congregate or home-delivered meal had significantly higher dietary intakes for a variety of key nutrients.

Additionally, the study examined a number of the non-nutritional aspects of the program such as socialization, recreation, support services, and nutrition education, and found that the vast majority of individuals surveyed both participated in these programs and derived some benefits from their involvement. In general, the findings of the study tend to support the effectiveness of the nutrition program.

### 3. ACTIVITIES OF THE NATIONAL DATA BASE ON AGING

The National Data Base on Aging (NDBA) is a joint undertaking of the National Association of State Units on Aging (NASUA) and the National Association of Area Agencies on Aging (N4A) funded by the Administration on Aging. The primary goal of the NDBA is to make available to a wide range of persons and organizations information on the services provided to older persons by State and area agencies on aging. The project was started in September 1981 and involved collecting baseline data from all State units and area agencies on aging. In August 1982, during the second phase of the project's operation, additional data was collected from the State units and from a one-third sample of area agencies. The project intends to sample a different group of AAA's in subsequent years, and utilize the baseline year (1981) for comparative purposes.

In general, the data base has provided, for the first time, a unique picture of the makeup and characteristics of State units on aging, AAA's, and the vast network of service providers operating throughout the country. Now in its third year of operation, NDBA has collected and analyzed a remarkable amount of information related to services provided to the elderly. At the present time, specific information concerning the general profile of State and area agencies, staffing patterns, functions, funding sources, and expenditures are available from the NDBA.

### 4. REGULATIONS FOR THE 1981 AMENDMENTS

On March 2, 1983, 14 months after the enactment of the 1981 amendments to the Older Americans Act, the Department of Health and Human Services published regulations to implement programs under the OAA. The proposed rules revised title III and title IV regulations published on March 31, 1980, and July 18, 1980, respectively, and incorporated appropriate provisions necessary to implement the 1981 amendments.

In conjunction with the Reagan administration's effort to reduce regulatory burden and provide State and area agencies with greater flexibility to respond to the needs of their respective populations, HHS established several rulemaking principles that were applied in the development of the regulations. Included in these principles were efforts aimed at not publishing rules that were duplicative of clearly established statutory provisions, efforts to eliminate regulatory provisions that did not serve a compelling Federal interest, and efforts to insure cost containment. The application of such principles resulted in the reduction of the combined title III and title IV regulations from 134 sections to 42 sections—a reduction of 92 sections. Of the 92 sections removed, HHS indicated, 62 were removed because they substantially repeated the statute, and 30 were removed to provide States and Indian tribes with greater flexibility in the development and operation of Older Americans Act programs.

Many national aging organizations felt that the administration had gone too far in revising the regulations, and that many of the sections that had been removed would seriously impair the ability of local programs to carry out their mandates under the act. Some observers noted that loss of certain sections would result in program inconsistency and problems with service delivery. The comments raised by these national organizations, as well as other individuals, resulted in some congressional review of the situation. On May 24, 1983, committee Chairman John Heinz and a number of other committee members sent a letter to AoA Commissioner Tolliver expressing concern on the proposed rules. In general, the committee was interested in retaining certain requirements in the existing regulations that supported the concept of a single organizational unit at the State and area agency level, retained the requirements for advisory councils, and maintained strong support for affirmative action planning. Further, the letter expressed concern with the proposed deletion of regulations that govern the long-term care ombudsman program, and noted the need to strongly reinforce the statutory provisions regarding legal services and the national nutrition programs.

Although numerous comments were received, by the end of 1983, final regulations had not been published by the Department.

## 5. OAA Funding for 1983

The 1981 amendments to the Older Americans Act (Public Law 97-115) provided for the following authorization levels from fiscal year 1982 through fiscal year 1984:

TABLE 4.—OLDER AMERICANS ACT AUTHORIZATIONS, FISCAL YEARS 1982, 1983, 1984 [1]

[In millions]

| | 1982 | 1983 | 1984 |
|---|---|---|---|
| Title II: Federal Council on Aging | $0.200 | $0.214 | $0.229 |
| Title III: | | | |
| Supportive services and senior centers | 306,000 | 327,400 | 350,300 |
| Congregate nutrition | 319,000 | 341,400 | 365,300 |
| Home-delivered nutrition | 60,000 | 64,200 | 68,700 |
| Title IV: Research, training, and demonstrations | 23,200 | 24,800 | 26,600 |
| Title V: Senior community services employment | 277,100 | 296,500 | 317,300 |
| USDA appropriation | 93,200 | 100,000 | 105,000 |

[1] Authorization levels are set as ceilings to the various titles under the act. Actual funding levels may differ depending on actions by the appropriations committees.

The Reagan administration's fiscal year 1983 budget request included a total of $652.2 million for programs operated by the Administration on Aging. This represented a reduction of $77.5 million from the fiscal year 1982 funding level. The largest decreases in program support were proposed in title III programs. Title III-B, supportive services and senior centers, were reduced by $24.7 million—a net reduction of about 10 percent. Title III-C congregate nutrition services were reduced by $28.6 million which represented an approximate loss of 10 percent, and home-delivered nutrition services were proposed to be reduced by $9.2 million—a 16-percent reduction. Reductions were also proposed for State agency administration ($1.7 million) and training, research and discretionary projects ($1.9 million).

In most cases, the proposals presented by the administration were rejected by Congress. The 1983 continuing resolution (Public Law 97-377) funded Older Americans Act programs through September 30, 1983, at a level of $671.7 million. The resolution provided for some modest increases in funding, with the largest increase directed at title III-C (nutrition). This increase provided $32.3 million more for congregate nutrition and an additional $4.7 million for home-delivered meals. The senior community services employment program (title V) was increased $4.8 million under the resolution. In addition, during 1983, Congress passed an emergency jobs-creation supplemental providing an additional $37.5 million for the title V program, thus, bringing its annual appropriation to $319.7 million.

TABLE 5.—*Older Americans Act fiscal year 1983 appropriations*

| | *Millions* |
|---|---|
| Title II: Federal Council on Aging | $.2 |
| Title III: | |
| State administration | 21.7 |
| Social services | 240.9 |
| Congregate meals | 321.6 |
| Home-delivered meals | 62.0 |
| USDA commodities (transfer) | 116.0 |
| Title IV: Training, research, and discretionary projects | 22.2 |
| Title V: Community service employment | 317.3 |
| Title VI: Grants to Indian tribes | 5.7 |
| Total | 1,107.6 |

## TABLE 6.—OLDER AMERICANS ACT APPROPRIATIONS, FISCAL YEARS 1970–84

[In thousands of dollars]

| | 1970 | 1971 | 1972 | 1973 | 1974 | 1975 | 1976 | 1977 | 1978 | 1979 | 1980 | 1981 | 1982 | 1983 | 1984 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Title II:[1] | | | | | | | | | | | | | | | |
| National Information and Resource Clearinghouse | (2) | (2) | (2) | None | None | None | None | None | 2,000 | 2,000 | 2,000 | 1,800 | 1,721 | None | None |
| Federal Council on the Aging | (2) | (2) | (2) | None | None | 0.575 | 0.0575 | .575 | .450 | .450 | .450 | .481 | .191 | 0.175 | 0.175 |
| Title III: | | | | | | | | | | | | | | | |
| Area planning[3] and social services | 9,000 | 9,000 | 30,000 | 68,000 | 68,000 | 82,000 | 93,000 | 122,000 | 193,000 | 196,970 | 246,970 | 251,473 | 240,869 | 240,869 | 240,869 |
| State agency activities[3] | 4,000 | 4,000 | 5,000 | 12,000 | 12,000 | 15,000 | 17,035 | 17,000 | 19,000 | 22,500 | 22,500 | 22,675 | 21,673 | 21,673 | 21,673 |
| Multipurpose senior centers | (2) | (2) | (2) | None | None | None | None | [4]20,000 | [4]40,000 | (5) | (5) | (5) | (5) | (5) | (5) |
| Nutrition program | (2) | (2) | (2) | 100,000 | 104,800 | 125,000 | [6]125,000 | 203,525 | 250,000 | 277,046 | 320,000 | 350,000 | 344,099 | 381,099 | 383,599 |
| Title IV: | | | | | | | | | | | | | | | |
| Training | 2,610 | 1,000 | 8,000 | 8,000 | 10,000 | 8,000 | 10,000 | 14,200 | 17,000 | 17,000 | 17,000 | | | | |
| Research | 3,250 | 2,800 | 9,000 | 9,000 | 7,000 | 7,000 | 8,000 | 8,500 | 8,500 | 8,500 | 8,500 | | | | |
| Model projects, special projects | None | None | 9,700 | 16,000 | 16,000 | 8,000 | 13,800 | 12,000 | 15,000 | 15,000 | 25,000 | [9]40,500 | [9]22,175 | [9]22,175 | [9]22,175 |
| Mortgage insurance and interest subsidies for senior centers | (2) | (2) | (2) | None | None | None | None | None | None | None | None | | | | |
| Multidisciplinary centers of gerontology | (2) | (2) | (2) | None | None | None | 1,000 | 3,800 | 3,800 | 3,800 | 3,800 | | | | |
| Title V: Community service employment for older Americans[7] | (2) | (2) | (2) | None | 10,000 | 42,000 | 55,900 | 90,600 | 209,900 | 200,900 | 266,900 | 277,100 | 277,100 | 319,520 | 317,300 |
| Title VI: Grants for Indian tribes | (2) | (2) | (2) | (2) | (2) | (2) | (2) | (2) | (2) | None | 6.000 | 6.000 | 5,735 | 5,735 | 5,735 |
| Foster grandparent program | 9,250 | 10,000 | 25,000 | 25,500 | (8) | (8) | (8) | (8) | (8) | (8) | (8) | (8) | (8) | (8) | (8) |
| Retired senior volunteer program | None | .500 | 15,000 | 15,000 | (8) | (8) | (8) | (8) | (8) | (8) | (8) | (8) | (8) | (8) | (8) |
| Total | 28,110 | 27,300 | 101,700 | 253,000 | 227,800 | 287,575 | 324,310 | 492,200 | 749,650 | 744,166 | 919,120 | 950,029 | 913,563 | 935,676 | 991,526 |

[1] The title numbers are based on the 1981 amendments.

[2] Not authorized.

[3] Between 1965 and 1970, title III funds were allocated to States for social services. There was no appropriation for State or area planning activities. Beginning in 1970 funds were appropriated for statewide planning. In 1973 funds were appropriated for area planning and social services.

[4] The appropriation covered grants, mortgage insurance and annual interest subsidies, but funds were allocated for grants only.

[5] Multipurpose senior centers are funded under the title III area planning and social services appropriation.

[6] Congressionally mandated operating levels made possible through forward funding were $150,000,000 for fiscal year 1975 and $187,500,000 for fiscal year 1976. Program operating level for fiscal year 1977 was $225,000,000.

[7] Funding is available on an annual basis beginning July 1 and ending the following June 30.

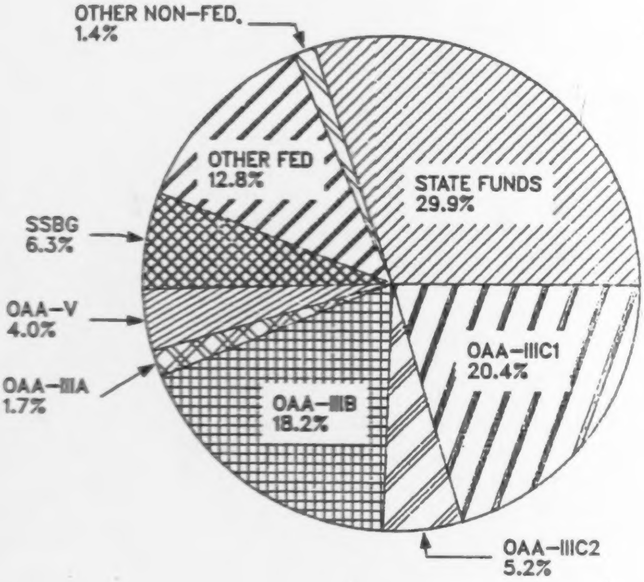
[8] The foster grandparent program was funded under a general poverty program through the Economic Opportunity Act from 1967 through 1968. This program was given a statutory basis under the Older Americans Act of 1969. In addition, the retired senior volunteer program was created under the 1979 amendments. Legislative authority under the Older Americans Act was repealed in 1973 and both these programs were reauthorized under the Domestic Volunteer Service Act of 1973 (Public Law 93–113).

[9] Includes funding for training, research, discretionary, and multidisciplinary centers for gerontology.

Finally, the National Data Base on Aging has provided a general picture on the sources of funding for States and area agencies. Charts 1 and 2 provide a visual representation of the funding for such agencies. The data are based on the annual sample for State and area agencies for 1982, and show that these agencies are utilizing other sources of funding besides those provided under the OAA.

CHART 1

WHICH FUNDING SOURCES COMPRISE STATE UNIT BUDGETS IN 1982 ?
TOTAL DOLLARS=$1,133,634,622
(38 STATE UNITS)



Other Federal Includes:

OAA Title IV
Medicaid
ACTION
Transportation
HUD
Low Income Energy Assistance
CSBG
USDA
CDBG
Other

Other Non-Federal Includes:

Private Funds
Inkind
Other

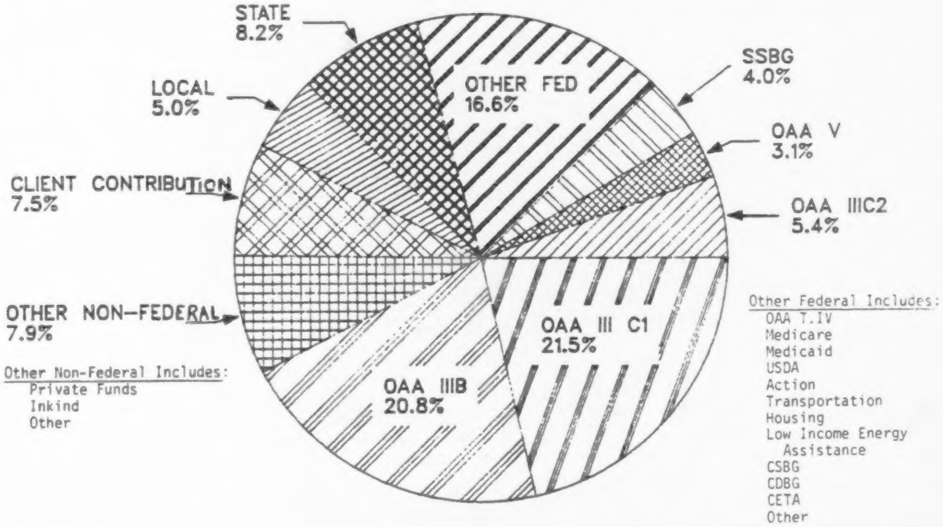
- From 1981 to 1982, the percentage of OAA and SSBG funds decreased while the percentage of State funds and other Federal funds increased.

CHART 2

## WHICH FUNDING SOURCES COMPRISE AREA AGENCY BUDGETS IN 1982 ?
## PERCENT OF DOLLARS
## (134 AAA)

- From 1981 to 1982, the percentage of funds derived from OAA, SSBG, and the State decreased, while the percentage of funds from all other sources increased.

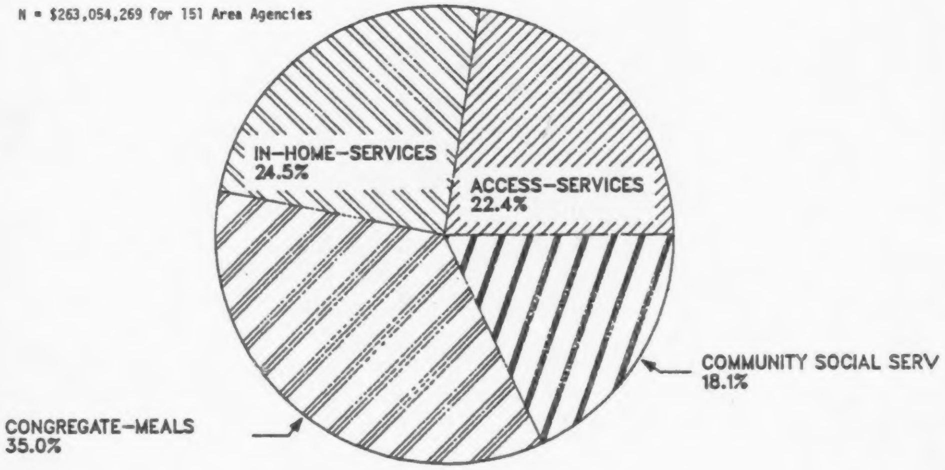
Total Dollars $280,696,542



In addition, Data Base has obtained data under the same sample information on the general expenditure patterns of area agencies. Chart 3 gives a breakdown of such expenditures by broad service categories.

CHART 3

## AREA AGENCY ON AGING SERVICE EXPENDITURES



## Chapter 18

# ACTION: VOLUNTEER PROGRAMS FOR OLDER AMERICANS

## OVERVIEW

Programs authorized under the Domestic Volunteer Service Act of 1973 and administered by ACTION include volunteers in service to America (VISTA), service learning programs, special volunteer programs (also referred to as the citizen participation/demonstration programs), and the older American volunteer programs (OAVP). Since its inception as a Federal program, ACTION agency volunteers have been involved in programs designed to reduce poverty, help the physically and mentally disabled, or serve in a variety of other community activities.

ACTION was established in 1971 under a reorganization plan which brought together seven existing volunteer programs into a single independent agency, and was given statutory authority in 1973 under the Domestic Volunteer Service Act, which repealed previous legislative authorities for the component programs and authorized several new volunteer activities.

Authorization for the Domestic Volunteer Service Act expired at the end of fiscal year 1983. On September 14, 1983, the Senate passed S. 1129, and on October 28, 1983, the House of Representatives passed an amended version of this bill. The House bill contains the text of H.R. 2655 which was the original House proposal. Both bills extend programs authorized under the Domestic Volunteer Service Act for 3 years—through fiscal year 1986. These bills were not conferenced in 1983. Both pieces of legislation included extensions of VISTA and OAVP programs. The reauthorization of VISTA was contrary to the administration's recommendation in its 1984 budget request to terminate the program. On the other hand, the administration had continued to support the volunteer programs for older Americans. Both the House and Senate bills include language to support the administration's position to broaden volunteer service opportunities in local communities, and to generate private sector resources for voluntary efforts.

The administration's budget request for fiscal year 1984 included $109.7 million for ACTION programs. The House- and Senate-passed budget resolutions assumed $136 million and $131 million, respectively, for programs under the act. At the close of fiscal year 1983, programs administered by the ACTION agency are being funded under the authority of a continuing resolution.

## A. VOLUNTEER SERVICES

In recent years there has been a strong resurgence of interest in the role that volunteers can play in both the public and the private nonprofit community service delivery system. Volunteer service has been a traditional means by which individuals and organizations have helped to meet social and cultural needs in the society. Historically, volunteerism has been thought as a regular commitment to institutions and organizations such as hospitals, nursing homes, orphanages, social service agencies, schools, churches, and other service-providing entities. In more recent years, volunteer service has included activities for informal self-help operations and other grassroots advocacy and community improvement programs. Volunteer services also may be on a short-term basis, such as helping a sick neighbor or contributing time to a special community function.

The need continues in many communities for volunteer efforts which address the problems of poverty and utilize the skills and experiences of an increasing number of citizens. A central theme of the Reagan administration's public policy has been to encourage increased individual and corporate responsibility in meeting local economic and social service needs. As part of the President's New Federalism initiatives, increased emphasis had been placed on shifting funding and management responsibility for many community services from the Federal level to State and local governments, and to the private sector. As this shift in Federal policy continues, greater pressure in helping to meet human needs will be directed toward the voluntary sector.

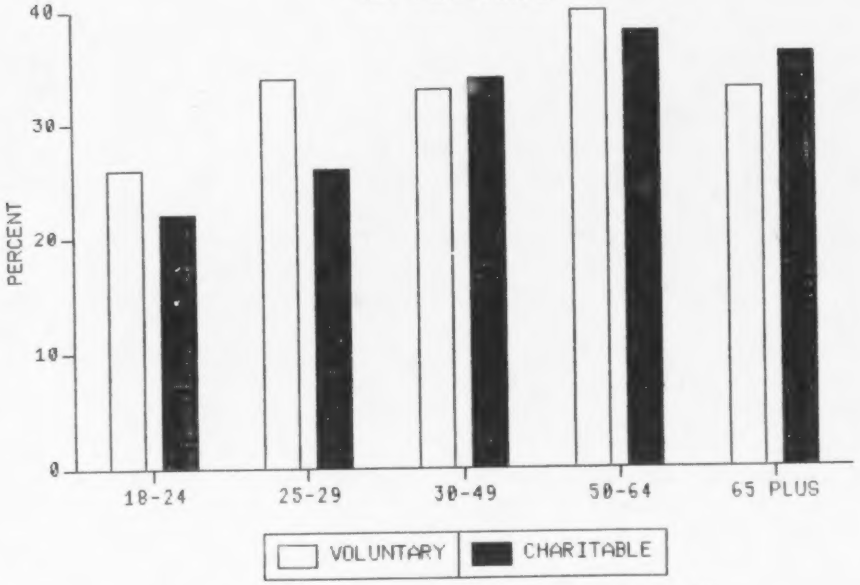
As noted above, volunteer services involve a variety of activities and encompass a wide range of individuals. A 1981 Gallup organization survey showed that an estimated 84 million Americans age 13 and over volunteered in 1980 for nonprofit organizations, neighborhood groups, and individuals. In general, most volunteer activity is in areas where people serve their own churches, schools, and neighborhoods. The social welfare area, in contrast, where government provides considerable support for direct service, is not as popular. This may reflect the fact that the volunteers are less likely to serve the low-income, disabled, elderly, and other needy individuals who traditionally have benefited from federally funded services.

More specifically, the Gallup survey showed that of all persons age 20 and over, the highest percentage did voluntary work in informal activities and in the areas of religious programs, health, education, and community action such as PTA and United Way.

As a result of current economic and political trends, innovative ways to recruit volunteers have been instituted in the private sector as well. In some instances, businesses have encouraged employees to donate their services to nonprofit social service providers, and some businesses have instituted liberal leave policies for volunteer activities. In addition, the increased number of retired individuals have become a growing resource for organizations relying on volunteer services. Chart 1 provides a comparative view of involvement in voluntary activities among different age groups.

CHART 1

INVOLVEMENT IN CHARITABLE AND VOLUNTARY ORGANIZATIONS BY AGE GROUP



SOURCE: RELIGION IN AMERICA, GALLUP REPORT, 1982

Volunteer participation in human services remains necessary in meeting community and national needs. As the magnitude of social problems and this country's fiscal dilemmas persist, closer collaboration between the voluntary, private, and public sectors will be essential.

## B. OLDER AMERICAN VOLUNTEER PROGRAMS

The older American volunteer programs (OAVP), which include the retired senior volunteer program (RSVP), the foster grandparent program (FGP), and the senior companion program (SCP), is the largest of the ACTION program components. For fiscal year 1983, OAVP funding constituted 69 percent of the total ACTION funding, and supports the majority of ACTION's volunteer strength. The various programs provide opportunities for persons 60 years of age and over to work part time in a variety of community service activities. Grants are awarded to local private nonprofit or public sponsoring agencies which recruit, place, supervise, and support older volunteers.

The Omnibus Budget Reconciliation Act of 1981 contained a 2-year authorization for the OAVP through fiscal year 1983. The legislation amended section 211 of the Domestic Volunteer Service Act to redesignate authorization for the senior companion program contained in part B as a separate part C. In addition to this change and changes in the authorization levels, no other significant alterations were made in the OAVP programs in 1981.

One significant facet of the OAVP is the extent to which Federal funding is supplemented by State and local resources. According to ACTION estimates, OAVP projects funding by Federal sources is estimated at over $14 million annually—$10 million for the FGP, and $2 million each for the retired senior volunteer and the senior companion programs. In fiscal year 1982, State funds generated to support each of the programs exceeded the Federal requirements for matching funds. The ACTION agency estimates that States provided an average of 24 percent of total funds used under FGP and an average of 23 percent of total funds under the SCP (compared to the Federal requirement for 10 percent matching funds for both programs); and an average of 40 percent under the RSVP (compared to the Federal requirement for between 10 and 30 percent matching funds, depending on the age of the project). To a great extent, the fact that these projects continue to generate additional funding at the State and local level have made them enormously popular with Congress and the administration.

During fiscal year 1983, ACTION promulgated final regulations clarifying and updating existing regulations relating to project development and funding, project operations, non-ACTION-funded projects and special limitations affecting aspects of project operations for all three OAVP programs. These regulations, part 1207 (SCP), part 1208 (FGP), and part 1209 (RSVP) of title 45 CFR were published in final form on June 10, 1983, in the Federal Register and became effective on July 25, 1983. Prior to their publication in final form, major comments were noted on both the senior companion program and the retired senior volunteer program. The major concerns expressed under the SCP related to the restrictions on the placement of senior companions in proprietary health care organizations. As a result of the comments received and the argument that senior companions assigned to such organizations do not function as staff but rather assume a one-to-one relationship with frail elderly who lack family or friends, ACTION dropped their proposed restrictions to proprietary health care organizations.

The other major area of controversy regarding the proposed regulations involved the matching requirements under the RSVP program. A provision added to Public Law 93-351 restricted the local share requirements to 10 percent in the first year of assistance, 20 percent in the second year, 30 percent in the third year, 40 percent in the fourth year, and 50 percent in the fifth and subsequent years, with the proviso that lesser local contributions should be permitted in situations of demonstrated need. Since 1976, however, ACTION has not required more than a 30-percent local contribution, since realities proved this to be the most feasible level. In responding to the comments, the final regulations stated that the percentages specified in the act would be used as a guide by ACTION in negotiating the level of local support, and that the level of local support may be higher or lower as mutually agreed to by ACTION and the local sponsor, and as justified by local conditions. This issue was further clarified in the proposed legislation for reauthorizing the Domestic Services Volunteer Act introduced in the first session of the 98th Congress (see committee report on S. 1129—Rept. No. 98-182).

The success of the OAVP program has led to a variety of collaborative arrangements and demonstration programs with other organizations in the social service area. These have included interagency agreements between the Department of Health and Human Services (DHHS) and ACTION, and between the Department of Justice and ACTION to support a number of innovative volunteer programs. These programs have included such demonstrations as using foster grandparents in the juvenile justice setting, utilizing the skills of RSVP volunteers in providing assistance in a number of head start programs, and employing the talents of selected senior companion and RSVP volunteers in working with the functionally impaired elderly under a demonstration program in community-based long-term care. During fiscal year 1983 these projects have been continued, and ACTION has been developing procedures for evaluating the effectiveness of these joint arrangements.

### 1. Retired Senior Volunteer Program (RSVP)

RSVP first received authorization in 1969 under the Older Americans Act. In 1971, the program was transferred from the Administration on Aging to ACTION, and in 1973 it was incorporated under title II of the Domestic Volunteer Service Act. The program is designed to provide volunteer opportunities for persons age 60 years and over in a variety of community settings. Volunteers serve in such areas as youth counseling, literacy enhancement, long-term care, crime prevention, refugee assistance, and housing rehabilitation. RSVP sponsors include State and local governments, universities and colleges, community organizations, and senior service organizations. Volunteers receive reimbursement for transportation, meals, and other out-of-pocket expenses.

The fiscal year 1983 appropriation of $27.4 million supported 345,200 volunteers in 730 projects throughout the country. For fiscal year 1984 the RSVP program is funded under the authority of a continuing resolution (Public Law 98–151) at a level of $27.4 million.

### 2. Foster Grandparent Program (FGP)

The FGP was originally developed in 1965 as a cooperative effort between the Office of Economic Opportunity and the Administration on Aging. It was given a legislative basis in 1969 under the Older Americans Act. In 1977, the program was transferred from the Administration on Aging to ACTION, and in 1973, the program was incorporated under title II of the Domestic Volunteer Service Act of 1973.

The FGP is designed to provide part-time volunteer opportunities for low-income persons age 60 years and over to assist them in providing supportive services to children with physical, mental, emotional, or social disabilities. Foster grandparents are placed with nonprofit sponsoring agencies such as schools, hospitals, day care centers, and institutions for the mentally or physically handicapped. Volunteers serve 20 hours a week and provide care on a one-to-one basis to three or four children. Current law allows a foster grandparent to continue providing services to a mentally retarded person over 21 years of age as long as that person was receiving services under the program prior to becoming 21.

Volunteers receive a stipend of $2 an hour, transportation assistance, an annual physical examination, insurance benefits, and meals when serving as volunteers. The Domestic Volunteer Service Act prohibits stipends from being subject to tax and from being treated as wages or compensation for purposes of unemployment, temporary disability, retirement, public assistance, or similar benefits. I order to enroll in the program, volunteers must have an income which is below the higher of 125 percent of DHHS poverty guidelines, or 100 percent of those guidelines plus the amount each State supplements the Federal SSI payment. The income level ranges from $6,080 for an individual in most States to $9,230 in Alaska in 1983. An enrolled participant may not continue to serve if income exceeds 120 percent of these limits.

The fiscal year 1983 appropriation of $48.4 million supported 18,100 volunteers in 244 projects throughout the country. Under the authority of a continuing resolution (Public Law 98-151), FGP is funded at a level of $48.4 million for fiscal year 1984.

### 3. Senior Companion Program (SCP)

The SCP was authorized in 1973 by Public Law 93-113 and incorporated under title II, section 211(b) of the Domestic Volunteer Service Act of 1973. The Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35) amended section 211 of the act to create a separate part C containing the authorization for the senior companion program.

The senior companion program is designed to provide part-time volunteer opportunities for low-income persons 60 years of age and over to assist them in providing supportive services to vulnerable, frail older persons. The volunteers primarily serve homebound, chronically disabled older persons in order to assist them to maintain independent living arrangements in their own place of residence. They also provide services to the institutionalized older person. Volunteers serve 20 hours per week and receive a stipend of $2 an hour, transportation assistance, an annual physical examination, insurance benefits, and meals when serving as volunteers. In order to participate in the program, volunteers must meet the income test as described above for the foster grandparent program.

During fiscal year 1983, 4,850 volunteers were supported in 76 local projects throughout the country. The appropriation for the program during fiscal year 1983 was $12.02 million. Under the continuing resolution, SCP will be funded at this same level for fiscal year 1984.

## C. LEGISLATION IN THE 98TH CONGRESS

Both the House and the Senate have passed bills to extend for 3 years (through fiscal year 1986) all ACTION programs, except for title I-B university year for ACTION, which has not been funded since 1981. S. 1129 was approved by the Senate on September 14, 1983. The House passed an amended bill on October 28, 1983. S. 1129 as passed by the House contains the text of H.R. 2655, the original House proposal. As of the end of calendar year 1983, the

House and Senate have not yet held a conference on the differences in the two versions.

In some respects the bills are similiar. In regard to VISTA, both bills would encourage the commitment of private sector resources, foster additional volunteer service at the local level, and expand the suggested list of activities for VISTA volunteers. The House, however, would authorize a considerable higher funding level for VISTA and require that 20 percent of all volunteers be age 55 and over. In addition, the House would establish a new program for providing financial and technical assistance for public and private voluntary efforts, while the Senate would provide such assistance under the existing title I–C special volunteer programs.

With respect to the older American volunteer programs, both bills would expand the SCP to focus on the needs of the homebound elderly and clarify foster grandparent services to mentally retarded persons over age 21. In addition, the House bill would increase the stipend amount made to foster grandparents and senior companions from $2 per hour to $2.20 per hour.

The Senate version of S. 1129, similar to the House would restrict the control of the Director of ACTION over non-Federal funds in excess of the required local contribution, and would clarify that volunteer stipends under OAVP would not be considered wages or compensation for purposes of worker compensation programs. Additionally, as mentioned above, both bills would expand SCP to assist homebound elderly and encourage the recruitment of unpaid volunteers (such as doctors, nurses, home economists, social workers) to train volunteers to provide needs assessments and in-home services to senior companion recipients. While the House bill requires this program expansion, the Senate bill authorizes such activities. Both bills authorize $12 million for each of the fiscal years 1984, 1985, and 1986 to carry out this expanded program.

## D. OAVP FUNDING

For fiscal year 1983, the older American volunteer programs were authorized at $100.7 million. The President's fiscal year 1983 budget requested $87.9 million for these programs, and final congressional action under the 1983 continuing resolution (Public Law 97–377) funded the programs through September 30, 1983 at the requested amount.

In the fiscal year 1984 budget request, the Reagan administration proposed to again level fund these programs at $87.9 million. The administration estimated that RSVP would support 359,000 part-time volunteers providing service in the areas of health, nutrition, education, refugee assistance, crime prevention, and other community services. Additionally, it estimated that 18,100 foster grandparent volunteers will serve about 54,000 children and approximately 4,800 volunteers in the SCP program will provide services to about 17,000 frail elderly persons. ACTION programs were not included in the regular Labor, HHS, Education, and related agencies appropriations bill because the programs were not authorized during the time of final passage of this bill. Instead, these programs are funded under a continuing resolution (Public Law 98–151) at a level of $87.9 million through September 30, 1984.

## OLDER AMERICAN VOLUNTEER PROGRAMS

[In millions]

| | Authorization levels, Public Law 97-35 | | Appropriations levels | | |
|---|---|---|---|---|---|
| | 1982 | 1983 | 1982 | 1983 | 1984 |
| RSVP | $28.691 | $30.412 | $26.338 | $27.445 | $27.445 |
| FGP | 49.67 | 52.65 | 40.079 | 48.40 | 48.40 |
| SCP | 16.6 | 17.670 | 12.170 | 12.016 | 12.016 |
| Total | 94.961 | 100.669 | 84.637 | 87.861 | 87.861 |

# Chapter 19

# LEGAL SERVICES

Older persons, because of difficulties of access and unique legal problems, have a special need for legal services. This need is greater today than ever, due in part to rapidly changing benefit programs.

Legal services help elderly persons obtain basic necessities and assure they receive what is due them. Legal problems of persons over 60 frequently stem from the policies and actions of governmental agencies which administer programs such as food stamps, supplemental security income payments, social security benefits, medicare and medicaid benefits, veterans benefits, and social services. These programs are often complex and difficult to understand for persons inexperienced with government. In addition to governmental benefits, legal problems of older persons typically relate to consumer fraud, property tax exemptions, special property tax assessments, guardianships, involuntary commitment to an institution, nursing home, and probate matters.

A large number of older persons cannot afford to hire a private attorney, particularly those who qualify for many benefit programs. Further, many older Americans face specific barriers to legal services because of lack of transportation, physical handicaps, fear of crime, and difficulty in communication.

## A. LEGAL SERVICES FOR OLDER PERSONS

Currently, a number of existing programs provide legal services for older persons. Programs funded under the social services block grant established under the Omnibus Reconciliation Act of 1981 (this block grant replaced programs originally operated under title XX of the Social Security Act), the Older Americans Act, and the Legal Services Corporation Act are among these programs.

### 1. Social Services Block Grant

Under the block grant program, Federal funds are allocated to States, which in turn provide services directly or contract with public and nonprofit social service agencies for providing social services to persons and families. States, for the most part, determine which social services to provide and for whom they shall be provided. Services may include legal aid. In fiscal year 1983, contributions to the Legal Services Corporation for the provision of legal services totaled more than $12 million. There is no information available on the number of persons or the age breakdown of those persons who are being served.

## 2. LEGAL SERVICES UNDER THE OLDER AMERICANS ACT

### (A) TITLE III-B

Support for legal services under the Older Americans Act (OAA) was a subject of interest to both the Congress and the Administration on Aging (AoA) for several years preceding the 1978 amendments to the OAA. There was no specific reference to legal services in the initial version of the OAA in 1965, but recommendations concerning legal services were among those made at the 1971 White House Conference on Aging.

Regulations promulgated by AoA in 1973, for the first time identified legal services as eligible for funding under title III of OAA. The amendments to the OAA in 1978, established a funding mechanism and a programmatic structure for legal services. Area agencies on aging are required by the OAA to allocate some title III social services funds to legal services and to contract with an appropriate provider of legal services. Legal Services Corporation (LSC) programs are identified by statute as suitable providers and have become the principal delivery mechanism for legal services under the OAA. Where a non-LSC provider is selected, that provider is required to coordinate services with the LSC-funded programs in its area. The LSC encourages its grantees to become OAA legal services providers and supports coordination between its programs and OAA legal services providers where a non-LSC provider is selected.

According to the AoA, the total amount of OAA title III-B funds obligated for legal services in fiscal year 1983 is not available. As a part of its efforts to reduce the reporting burdens on States, the AoA no longer collects from each State its obligations of title III-B funds for legal services. AoA believes it will be able to estimate the national level of expenditures, units of service, and number of clients for legal services from sample data collected through the National Association of State Units on Aging and the National Association of Area Agencies on Aging. Sample data for the time period, including fiscal year 1983, is expected to be available in the spring of 1984. In 1982, it was $13 million.

Approximately 6 percent of all title III social services funds were spent on legal services. Of the nearly 700 area agencies on aging, about 80 percent of them directly fund legal service programs as required under the OAA. Other providers have secured funding from sources other than title III-B, as allowed under the OAA. The number of older persons receiving legal services through the area agencies on aging rose from 301,000 served in fiscal year 1979, to 507,000 in fiscal year 1982, an increase of 41 percent over a 3-year period.

The number of LSC programs receiving OAA funds has grown steadily from year to year. In 1982, 154, LSC field programs (approximately one-half of such programs) reported a total of $9.1 million in OAA funds. In 1983, 173 LSC programs received OAA funding totaling $8.8 million. Fifty-six percent of all LSC field programs currently receive such funding. It should be noted that the total amounts allocated for legal services by area agencies as well as the total amounts reported by LSC projects declined slightly from fiscal year 1981 levels, in part as a result of the reduction in funding for the OAA title III-B programs.

The OAA requires that OAA funding not be used to supplant services funded by the LSC. A 1979 survey of 13 LSC programs disclosed that the OAA funding resulted in substantial allocation of LSC funds to special delivery units which serve the elderly, funded by both LSC and OAA. Another indication of the impact of OAA funding on LSC programs is that, in 1981, approximately 15.4 percent of the clients of LSC programs with OAA funding were over age 60, while projects without OAA funding served a clientele of whom, on average, only 11.56 percent were over the age of 60.

The OAA requires State agencies on aging to establish and operate a long-term care ombudsman program which, among other things, investigates and resolves complaints made by or on behalf of older residents of long-term care facilities. The 1981 amendments to the OAA expanded the required scope of the ombudsman program to include board and care facilities. In many States and localities, there is a close and mutually supportive relationship between State and local ombudsman programs and legal services programs.

The AoA has stressed the importance of such a relationship and provides grants to the States designed to further ombudsman, legal, and protective services activities for older people and to assure coordination between these activities. State ombudsman reports indicate that through both formal and informal agreements, legal services attorneys and paralegals help ombudsmen secure access to facilities, residents, and residents' records; provide consultation to ombudsmen on laws and regulations affecting institutionalized persons; represent clients referred by ombudsman programs; and work with ombudsmen and others to bring about changes in policies, laws, and regulations which benefit older persons in institutions.

### (B) TITLE IV

Since 1980, the AoA has provided more than $16 million under title IV for legal service-related functions, including such activities as technical assistance and training efforts to strengthen legal representation for the elderly. The AoA has allocated the bulk of OAA title IV funds earmarked for legal services to grants to State agencies on aging for "legal service developers." These State legal services development grants have served to support and coordinate publicly and privately provided legal services for older persons in that State. State responses to this provision, however, have been irregular, and many states now have vacancies in this position.

An estimated $2.1 million was used by States in fiscal year 1983 for legal services developer activities under title IV discretionary grants. It should be noted, however, that this total figure includes a variety of activities associated with protective services; no data is available which separates the amount of funds used for these two activities.

The following grants were awarded in 1983 to public and private organizations for model projects under title IV for legal services:

(1) American Bar Association—to develop materials and recruit corporate legal counsels to provide pro bono legal services to older persons.

(2) American Association of Retired Persons (AARP)—to provide guardians for incapacitated older persons using the AARP chapters as resources for volunteers.

In addition, there are three projects designed to develop models for prevention of abuse of older persons, and to demonstrate effective intervention techniques. These projects have been awarded to the Rhode Island elder abuse project, the Massachusetts elder abuse project, and the Syracuse elder abuse project.

Funds were also used to support three training projects which support the development of legal services:

(1) Wayne County Community College, Detroit, Mich.—to sensitize law enforcement professionals and volunteers to the special problems of older persons.

(2) San Diego State University, San Diego, Calif.—to develop and acquire accreditation for a training program in aging issues for police officers.

(3) Middlesex Community College, Bedford, Maine—to train volunteers in peer counseling and criminal justice procedures to mediate with law enforcement agencies in behalf of older persons.

## 3. Legal Services Corporation

### (A) HISTORY

Legislation creating the LSC was enacted in July 1974. Previously, legal services had been a program of the Office of Economic Opportunity, added to the Economic Opportunity Act of 1966. Public Law 93-355 established the legal services program as a private nonprofit corporation headed by an 11-member board of directors, nominated by the President and confirmed by the Senate.

The Corporation does not provide legal services directly; rather, it funds local legal aid projects. Each local legal service project is headed by a board of directors, of which 60 percent are lawyers who have been admitted to a State bar. The Corporation also funds a number of national support centers, which develop and provide specialized expertise in various aspects of poverty law to legal services attorneys in the field.

Legal services provided through Corporation funds are available only in civil matters and to individuals with incomes no higher than a set standard which utilizes the Office of Management and Budget poverty guidelines. Several restrictions on the types of cases legal services attorneys may handle were included in the original law and several others have been added since then.

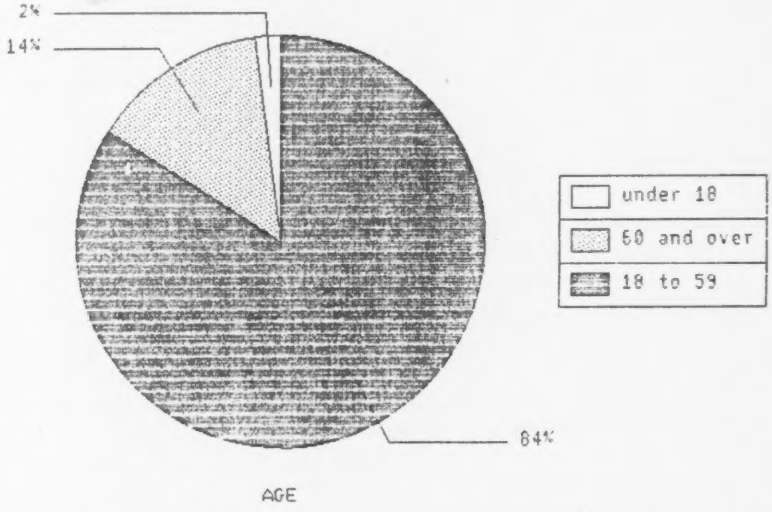
During fiscal year 1976, its first full year of operation, the Corporation was funded at $92.3 million. Funding for LSC reached its peak in fiscal year 1981, with funding of $321 million. Since 1981, LSC funding was reduced by 25 percent to $241 million.

### (B) CURRENT STATUS

At the start of 1983, there were 326 legal services programs throughout the 50 States, the District of Columbia, the Virgin Islands, Puerto Rico, Micronesia, and Guam. The number of field program offices at the start of 1983 was 1,121. This compares to 1,187 in 1982 and 1,475 in 1981. At the beginning of 1983, the LSC employed 4,791 attorneys in its field programs, as compared to 6,337 in 1981 and 4,564 in 1982. LSC programs handled and closed 1,141,481 cases in fiscal year 1982, less than the 1,221,594 cases closed in 1981.

Although programs funded under the Legal Services Corporation Act make services available to all low-income persons, persons 60 years of age and older constitute a sizable portion of the client eligible population. Fourteen percent, or 154,751 of the cases handled in 1982, involved a client age 60 and over. This figure represents an increase over previous year levels of 12.1 percent in fiscal year 1980 and 12.9 percent in fiscal year 1981.

CHART ONE
CLIENT CHARACTERISTICS OF LEGAL SERVICES CORPORATION BY AGE
1982



Source: Legal Services Corporation, February, 1983

LSC programs help older clients by engaging in legal representation or advice to individuals and groups, community education, outreach, training for social services workers, and information and referral. Most of the cases for older persons involve Government benefits, particularly social security, supplemental security income, medicaid, and medicare. Other legal matters include housing, consumer, long-term care, pensions, guardianship, age discrimination in services and in employment, some wills, and simple estates.

At the national level, the LSC has funded a number of national support centers which are involved in issues that confront older people. These include the National Senior Citizen Law Center (NSCLC) in Los Angeles and Washington, D.C.; Legal Counsel for the Elderly (LCE) in Washington, D.C.; and Legal Services for the Elderly (LSE) in New York City.

NSCLC is a national support center providing assistance to local legal services program staff throughout the country on legal issues unique to the elderly. LSC provides legal representation to older persons in the District of Columbia, using a combination of staff attorneys and a large contingent of volunteer attorneys and nonattorneys. LSE provides specialized litigation and State support for the elderly, particularly in the areas of employment and pension law. LSC and its national support projects publish numerous studies, training manuals, research papers, and handbooks on legal issues of concern to older persons. Recent materials cover social security, housing, long-term care, energy assistance, and access to legal services.

In 1983, LSC sponsored a conference entitled "Creative Delivery of Legal Services to the Elderly," a 3-day meeting in Washington, D.C., for legal services programs for the elderly. LSC also continued to maintain a special unit on aging in its Washington, D.C., office to assist local programs in working with the aging services system and to serve as a liaison with AoA.

### (C) REAUTHORIZATION

The LSC has operated without formal authorizing legislation since the end of fiscal year 1980. Committees in both the House and Senate reported legislation during 1980 to extend the LSC. The full Senate passed its version of the bill, but LSC supporters in the House, fearful that numerous amendments were pending that would have drastically restricted the scope of the Corporation's work, chose not to bring the reauthorization bill before the full House for a vote. Instead, a continuing resolution for 1981 served as the funding and authorizing measure for LSC.

In 1981, the House Judiciary Committee reported legislation to continue the Corporation for 2 more years. The full House passed the bill, but the Senate took no action in 1981 or 1982. As a result, the LSC was again both funded and authorized by continuing resolutions during fiscal year 1982 and fiscal year 1983. On May 12, 1983, the House Judiciary Committee approved another LSC reauthorization bill (H. Rept. 98-201). H.R. 2909 would authorize the Corporation through fiscal year 1986, at a level of $296 million in fiscal year 1984, and "such sums as necessary" thereafter. On April 21, 1983, Senator Eagleton introduced S. 2133, to reauthorize the LSC through fiscal year 1986, and containing similar provisions to H.R. 2909. Senator Hatch introduced S. 1838 on September 14, 1983, which would reauthorize the LSC through fiscal year 1986, at an annual level of $241 million. Further action is anticipated to form a compromise between S. 2133 and S. 1838.

### (D) FUNDING

As he had done in 1982, in his fiscal year 1983 budget proposal to Congress, submitted February 8, 1982, President Reagan requested no funds for LSC and suggested that its activities could be continued either by the private bar or through the social services block grant. Congress, however, again rejected this proposal and eventually included the LSC in continuing resolutions for fiscal year 1983.

On August 10, 1982, the House Appropriations Committee approved H.R. 6957, containing $241 million for the LSC in 1983. Although H.R. 6957 passed the House, no action on this bill was taken in the Senate. Instead, Congress approved, and the President signed, a temporary continuing appropriations resolution, to be in effect through December 17, 1982 (Public Law 97-296). The measure contained the then current operating level, or $241 million, for the LSC. Additionally, the legislation contained restrictions on LSC activities.

Public Law 97-377 was signed by President Reagan on December 21, 1982, and was effective through September 30, 1983. This resolution continued funding for the LSC at the annual level of $241 million. In addition, the continuing resolution contained new language limiting fees paid to LSC board members. This language was inserted by Congress after press reports indicated that the LSC board of directors had received larger-than-usual consulting fees, and that the LSC president had received employee benefits considered overly generous.

President Reagan continued to request no funding for LSC in fiscal year 1984. The Corporation itself, however, is allowed to submit its own funding proposal and asked for $257 million.

The full House Appropriations Committee endorsed $296 million for fiscal year 1984 in H.R. 3222, reported on June 3, 1983. The full House passed H.R. 3222 on September 19, 1983, by a vote of 228 to 142.

Meanwhile, on August 2, 1983, the Senate Appropriations Committee reported S. 1721, containing $257 million for the LSC. Because final action had not occurred on these bills when fiscal year 1984 began October 1, 1983, the LSC was included in a continuing resolution (Public Law 98-107), at an annualized level of $275 million. This resolution contained the same funding restrictions as the fiscal year 1983 continuing resolution.

The final version of H.R. 3222 was passed by Congress and signed by President Reagan on November 28, 1983, containing $275 million for LSC in fiscal year 1984.. Funding restrictions in the law concern lobbying, class action suits, representation of aliens, training programs, composition of recipient's governing bodies, termination of funding, compensation and fringe benefits for board members and employees, and limitations on the action of unconfirmed board members.

Most recently, on January 6, 1984, the board of directors of the LSC voted to request a fiscal year 1985 budget of $325 million, an 18-percent increase over 1984 budget allotments and the largest ever sought by the Corporation. The board earmarked $20 million of this proposed budget for hiring private attorneys for legal aid cases.

The availability of legal representation for low-income older persons is determined, in part, by the availability of funding for legal services programs. A 1979 study of elderly legal services under the OAA concluded that lack of funds is the most important inhibiting factor for the provision of legal services to the elderly. In that study, the amount of title III funds reported to be spent per older person was found to be extremely low. Levels and maintenance of funding continue to be a prominent issue, as is evidenced by the report on a conference of the LSC entitled, "Working Successfully With the Aging Network," held in Denver, Colo., in 1982. Conference participants expressed concern regarding the maintenance of funding for existing legal services elderly programs, given the trend in recent years to cut back the flow of national funds from both AoA and LSC to local programs for delivery of elderly legal services.

Since 1981, Congress has reduced funding to the LSC by 25 percent. This funding reduction translates in the loss of 1,773 attorneys and the closing of more than 300 local offices, making it more difficult for older persons with legal needs to gain access to legal representation.

The Washington Council of Lawyers, a voluntary, nonpartisan bar association, conducted a survey in the spring of 1983, to measure the impact of the 25-percent reduction in Federal funding for the LSC on the quality and scope of legal representation to the poor. Sixty-one programs, representing 20 percent of all field programs and serving 45 percent of the total eligible client population in the United States, responded to the survey questionnaire. Results of the study were published in a report entitled "Report on the Status of Legal Services for the Poor," issued in November 1983.

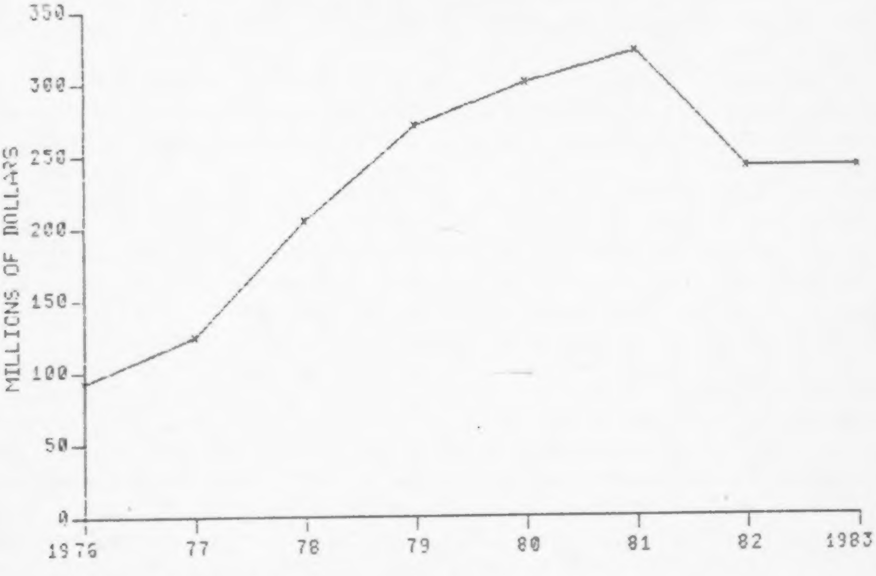
According to this report, the average overall loss in funding for all programs surveyed was 25.6 percent, and the average inflation-adjusted loss in funding was 29.7 percent. A majority of programs reported they failed in their attempts to replace any of the lost Federal funds through State, local, or private sources. Overall, programs lost almost one-third of their staff attorneys and efforts to replace attorneys were substantially impaired by uncertainties as to future funding. Cuts in funding coincided with a national economic recession creating a category of "new poor" and changes in Federal programs creating new legal needs for the poor.

The authors concluded that the population eligible for legal services increased by 14.5 percent in the last 2 years, from 40.6 million individuals in 1980 to 46.5 million in 1982. Programs surveyed reported that more than one-third of the full- and part-time offices operated by the surveyed programs in 1981 had been closed, reduced in size, or merged into other offices by 1983. In both urban and rural areas, the report noted, clients no longer served because of office closings have had significant difficulty obtaining alternative legal assistance.

Program responses indicated that the private bar, though responsive in many cases, has not been able to fill the gap. Program caseloads were lower for four out of five programs in 1983, largely as a result of a lack of sufficient staff to handle the demand. Most of the programs reported having to turn away more than 500 poor people without providing any legal representation, and 27 programs each turned away over 2,000 poor people without providing any advice or legal representation. In addition, as a result of the funding cuts, field programs were forced to eliminate specialized units, such as elderly units, and to curtail State and local training programs. The report stated that the results of the survey showed a decrease in the ability of the LSC grantees to provide full professional representation to eligible clients in 1983.

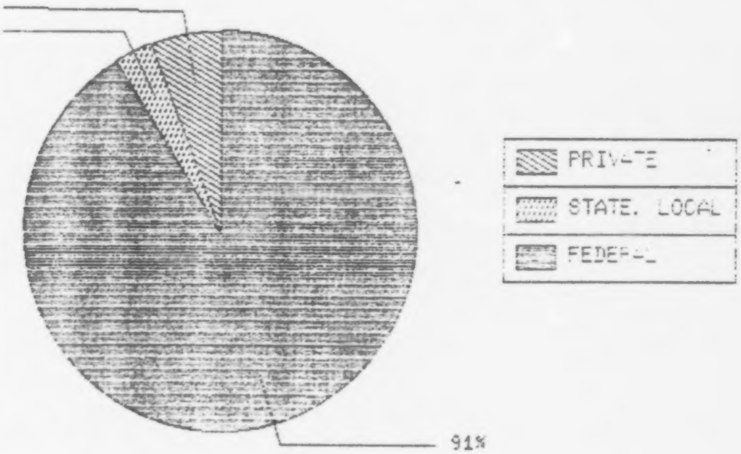
When the LSC was established in 1975, its foremost goal was to provide all low-income people with at least "minimum access" to legal services, defined as the equivalent of two legal services attorneys for every 10,000 poor people. The goal of minimum access was first achieved in fiscal year 1980, with an appropriation of $300 million. Currently, however, the LSC is not funded to provide minimum access to legal assistance to poor persons. In most States, only one attorney serves 10,000 poor persons, and more than one of the three LSC-funded programs is staffed at levels of less than half of this minimum access standard. To meet the minimum access level now, the National Legal Aid and Defender Association has estimated that the Corporation would need a fiscal year 1985 budget of $470 million, over 40 percent more than LSC directors voted to request and 70 percent over the current budget.

CHART TWO
LEGAL SERVICES CORPORATION APPROPRIATIONS
1976-1983



Source: Legal Services Corporation

CHART THREE
DISTRIBUTION OF LEGAL SERVICES FUNDS BY SOURCE



Source: Legal Services Corporation, February, 1983

### (E) BOARD OF DIRECTORS

During the summer of 1981, the appointments of all 11 LSC board members appointed by former President Carter expired. On New Year's Eve 1981, the administration made 11 new appointments. Because these individuals were appointed during a congressional recess, they could serve without Senate confirmation until the end of the 97th Congress (December 1982). The administration, however, decided to submit 10 of the names for confirmation in March 1982, although one of the nominees subsequently requested that his name be withdrawn.

In July, the Senate Labor and Human Resources Committee recommended confirmation of all but two Presidential nominations. The full Senate took no action on the nominations because of the ongoing controversy surrounding two recess appointees who were perceived as opponents of the LSC and who did not gain approval of the Labor and Human Resources Committee. In December 1982, press accounts revealed that the LSC board members appointed by President Reagan had been receiving extraordinarily large consulting fees for their services and that the LSC president, chosen by the board of directors, was given unusually generous fringe benefits in his contract.

President Reagan withdrew all nominees later that month, with the exception of two individuals whom he appointed in October and whose terms were still running. A subsequent Office of Management and Budget report, released January 1983, cleared the former board members of any wrongdoing. The General Accounting Office also issued a report in September 1983, which found no violations of law or regulation by the former board members. In January 1983, President Reagan made four additional recess appointments to the LSC board. One subsequently withdrew and another was appointed in November 1983. In January 1984, President Reagan made two more recess appointments. Thus, 6 of the board's 11 seats are currently filled, and all are recess appointments.

President Reagan announced that he would nominate a full complement of 11 members to the LSC board in October 1983. Of these 11, 6 were formally nominated in October and 2 more were nominated in November. Hearings were held by the Senate Labor and Human Resources Committee on these nominations. Before Congress recessed in November 1983, two attempts by Committee Chairman Orrin Hatch to recommend confirmation of the nominees failed because the committee lacked a quorum at its meetings.

### (F) ELIGIBILITY REGULATIONS

Funding reductions for the Corporation since 1981 have prompted it to reexamine criteria governing eligibility for legal services, so as to focus resources on those persons most in need. Eligibility regulations were considered before the LSC Operations and Regulations Committee meetings on July 18 and August 23, 1983. Proposed new regulations setting forth revised eligibility criteria for legal services were published in the Federal Register by the LSC on August 29, 1983, and the public was granted until September 28, 1983, to comment. Extensive comments were received and certain provisions were rewritten to take account of the concerns expressed. The LSC board of directors approved the revised rules at a public meeting held in San Francisco on November 7, 1983. The final rules were published in the Federal Register on November 30, 1983.

The final rules set a uniform absolute ceiling at 150 percent of the "national eligibility level," which is 125 percent of the poverty line. Thus, under the regulations, no one whose income exceeds 187.5 percent of the poverty level could be served unless a person's income is primarily committed to medical or nursing home expenses.

Recipients must set guidelines incorporating specific asset ceilings and transmit these guidelines to the Corporation on an annual basis. These guidelines must include both liquid and nonliquid assets and take into consideration local economic and cost-of-living factors. Income from Federal benefit programs must be counted. The assets of all persons who are resident members of a family unit are to be considered, although the recipient may exclude the principal residence of a client. Another change requires recipients to document and include in the client's file, for use by the Corporation, the reasons for serving any client whose income exceeds 125 percent of poverty.

Additionally, the new rules delete a provision in the former rules which allowed benefits from a governmental income maintenance program not to be counted as income for the purpose of determining eligibility. Under the previous rules, persons receiving food stamps, AFDC, SSI, and other public benefits were automatically eligible for legal aid. Another provision of the regulations restricts group eligibility to groups composed primarily of eligible clients and requires each group to provide information that it lacks funds to retain private counsel. The final rules also require a written retainer agreement and a redetermination of eligibility based on a change in circumstances.

### 4. Private Bar

An essential component of the legal services delivery systems for the elderly is the private bar. The expertise of the private bar is considered especially important in such areas as wills and estates, real estate and tax planning. Although many have cited the capacity of the private bar to meet some of the legal needs of the elderly on a full-fee, low-fee, or no-fee (pro bono) basis, the potential of the private bar to serve the elderly in need of legal assistance has not yet been fully realized. Efforts to encourage private bar involvement, however, are well underway.

In 1981, the LSC adopted a requirement that every LSC program expend at least 10 percent of its funds on efforts to utilize the private par to serve low-income persons. In some areas, LSC and OAA funding support pro bono projects for the elderly which complement the work of legal services programs.

Recognition of the importance of drawing upon the entire legal profession to meet the needs of the elderly is also reflected in the Older Americans Act, which emphasizes the role of the private bar. Agreements between title III legal services programs and the private bar have taken various forms. One form is volunteer lawyers projects, which are open to all members of the bar who are willing to provide free legal services to eligible older persons. These programs employ small administrative staffs to handle client intake and screening, attorney recruitment and referrals. Programs' staff attorneys provide backup legal assistance to private bar participants along with some direct services to clients.

Another method used is lawyer referral programs which provide reduced fee legal services to middle- to low-income individuals with incomes too high to qualify for free legal services, but too low to afford customary attorneys' fees.

Legal services are also provided through corporate counsel programs. Corporate attorneys are matched with title III attorneys to extend office hours and outreach, and to accept specific kinds of cases. Title III money also has been used to support contracts with individual private attorneys who give free legal services to older persons in economic and social need in exchange for area agency on aging funds. With the increased emphasis on private bar involvement, and with the attractiveness of leveraging resources, the opportunity to design more comprehensive legal service programs for the elderly exists.

### 5. American Bar Association

The Commission on Legal Problems of the Elderly, American Bar Association was created in 1978 to promote the development of legal resources for older persons generally, and to involve the private bar in responding to the needs of the aged. During 1983, the

Commission continued its varied activities in the development of bar-sponsored lawyer referral, pro bono and community education projects throughout the Nation. Additionally, the Commission received a grant from the Administration on Aging for an innovative project called the corporate counsel project. The project seeks to generate corporate law department public service activity to assist older persons in need of legal advice and representation. The Commission is preparing a handbook for use by corporate law departments, is contacting individual corporations to intiate programs, and has established an ABA Task Force on Corporate Law Department Public Service Programs to spur interest in corporate public service programs.

As of July 1983, the Commission on Legal Problems of the Elderly reported that over 28 State and several local bar associations have committees on the elderly, many of which are actively involved in delivery projects. There are several statewide referral systems for the elderly in operation, as well as several State preventive law community education projects for senior citizens. Over a dozen States have sought to enhance the knowledge of bar members by providing continuing legal education sessions on law and aging. Over 60 local bar projects currently operating, or shortly to begin operation, involve volunteer private lawyers, low-fee referral systems, and community education.

The ABA has also stated, however, that private bar efforts alone fall far short in providing for the needs of older Americans for legal help. They have consistently maintained that the most effective approach for providing adequate legal representation and advice for needy older persons is through the combined efforts of a continuing Legal Services Corporation, an effective Older Americans Act program, and the private bar.

## B. NEED FOR LEGAL ASSISTANCE

The national population segment from which the need for elderly services arises is large and growing. The AoA and the LSC reporting system count older persons on the basis of those over the age of 60. Over 36 million Americans were over age 60 in 1982, roughly 16 percent of the population. Persons over 60 constitute 14.6 percent of all persons below the official Government poverty line. This is approximately 5 million persons. Under 1983 LSC eligibility requirements, individuals with incomes up to 125 percent of the poverty line may be eligible for LSC funded legal assistance. Using this standard, approximately 8.7 million persons over the age of 60 are LSC eligible persons.

Unfortunately, there is no precise way of determining eligibility for legal services under the Older Americans Act since eligibility is based both upon economic and social need, and means testing for eligibility is prohibited. An expert in the field has stated that if one were to consider the potential clientele for Older Americans Act legal services as those realistically unable to afford legal assistance, a majority of older persons would qualify for such legal assistance. Fully two-thirds of persons over 65 in 1980 had incomes of less than $8,000 per year. Of older persons over 65 and living alone, more than 60 percent had annual incomes of less than $5,000 a year, and 75 percent had annual incomes of less than $7,000. A substantial percentage of older persons are poor or near poor and would find it difficult to purchase legal representation.

## C. CONGRESSIONAL HEARINGS

On July 12, 1983, Senator Charles E. Grassley chaired a hearing before the Subcommittee on Aging, U.S. Senate Committee on Labor and Human Resources entitled "Judicial Access and the Elderly." Senator Grassley stated that the purpose of the hearing was to examine whether the congressional mandate contained in 1974 Legal Services Act was being met by the Corporation as presently constituted. Section 1007 of the act requires that LSC "adopt procedures for determining and implementing priorities for the provison of * * * assistance, taking into account the relative needs of eligible clients for such assistance, including particularly the needs of eligible clients with special difficulties of access to legal services or special legal problems (including elderly * * * individuals)." In addition, the hearing focused on how the special legal needs of the elderly are being met by the AoA and by efforts of the private bar. Senator Grassley stated that Government legal services programs serving the elderly will best meet their needs by providing direct client services to as many individuals as possible.

Witnesses at the hearing included: M. Gene Handlesman, Deputy Director, Administration on Aging; Russell Proffitt, chairman, Iowa Association of Area Agencies on Aging; Karen Tynes, director, Iowa Commission on Aging; Gregg Hartley, Director, Office of Field Services, Legal Services Corporation; Jonathan Weiss, Legal Services for the Elderly, New York City; Wayne Moore, legal counsel for the elderly, American Association of Retired Persons; Burton Fretz and Bruce Fried, National Senior Citizens Law Center, Washington, D.C.; Nancy Coleman, Commission on Legal Problems of the Elderly, American Bar Association; and Daniel L. Power, professor, Drake University Law School Legal Clinic.

On September 22, 1983, Congressman Biaggi convened a hearing of the Human Services Subcommittee, House Select Committee on Aging, to examine the impact of proposed Legal Services Corporation eligibility regulations upon the elderly. The hearing was conducted to receive public input from interested persons prior to the end of the comment period.

Witnesses at the hearing included: Senator John Heinz; Congressman Ron Wyden; Congressman Bruce A. Morrison; Donald P. Bogard, President, Legal Services Corporation; Edna Sansone, Annandale, Va.; Claudia McNeil, Alexandria, Va.; Lyman M. Tondel, chairperson, Commission on Legal Problems of the Elderly, American Bar Association; Eugene Callender, director, New York State Office for the Aging; John David Kennedy, executive director, Pine Tree Legal Services, Portland, Maine; Jacob Clayman, president, National Council of Senior Citizens; James Hacking, assistant legislative counsel, American Association of Retired Persons; Elma Holder, executive director, National Citizens Coalition for Nursing Home Reform; David Affeldt, representing the National Pacific/Asian Resource Center on Aging and the Asociacion Nacional Pro Personas Mayores; David Raphael, director, Rural America; Alice

Quinlan, government relations director, Older Women's League; Scott Marshall, director of Government Affairs, American Council of the Blind; Robert Plotkin, member, Legal Rights Committee, National Mental Health Association; and Don Galloway, director, D.C. Services for Independent Living.

Most of the witnesses objected to proposed rules mandating an assets test, including such things as home equity, value of work-related equipment, and transportation vehicles for medical and employment purposes, elimination of group representation services, and elimination of existing law which makes those persons receiving public benefits automatically eligible for legal services. Senator John Heinz called the proposed rules "patently dircriminatory against older Americans" and said that the rules would sharply narrow access of the elderly to legal services. Senator Heniz joined Congressman Biaggi in calling for the withdrawal of the proposed regulations.

# Chapter 20

# SOCIAL AND COMMUNITY SERVICES

## OVERVIEW

The plethora of social and community services available to older Americans today is staggering. They are primarily funded through public, private, nonprofit, voluntary, and religious organizations. Historically, however, private and quasi-public groups have been their mainstay. Although the Federal Government has mounted a vast array of services and service systems, actually only a small part of the funding currently being spent for social and community services goes to benefit the elderly. Most of the government spending in the budget directed at older persons is for income maintenance and health care insurance.

These federally supported senior services are funded through three major types of grant programs: categorical, block, and revenue sharing.

Categorical grants fund well-defined programs designed to aid special population groups. They include a majority of the federally supported social services for older people, of which the most important is the Older Americans Act.

Another mechanism for distributing Federal dollars is the block grant, which authorizes funds for a wide variety of local programs and services and gives the State and local government units discretion as to what is offered to whom, when, and where. An example of this approach are programs funded under the social services and community services block grants.

A third type of program that affects the elderly and senior services is revenue sharing. This program distributes federally collected tax moneys on a formula basis to State and local governments. Since there are so few restrictions on reporting requirements on these funds, it is impossible to tell on a nationwide basis how much actually goes to support services for the elderly, although it is generally agreed that it is a very small portion.

This chapter examines four general program areas that provide a variety of social and community services to older adults. Included in this review are programs funded under the social and community services block grants, and programs that fund transportation and educational services.

## A. SOCIAL SERVICES BLOCK GRANT (TITLE XX)

The Federal Government entered the field of social insurance for needy citizens in 1935, after the Great Depression had overwhelmed the resources of private, State, and local groups, which previously had been the sole providers of aid to the poor. The landmark Social Security Act of 1935 aimed to ease the financial burden of aged and retired workers, the temporarily unemployed, and other needy individuals who could not work for a variety of reasons. For the first time, the Federal Government paid half the cost of providing cash assistance, although States continued to determine benefit and eligibility levels.

Social services for welfare recipients were not included in the original Social Security Act, although it was later argued that cash alone would not meet all the needs of the poor. Federally funded social services for welfare recipients were first authorized in 1956 under various provisions of the Social Security Act. In the past, the program operated as an open-ended entitlement to States and spending grew rapidly in the late 1960's until a nationwide Federal expenditure ceiling was imposed in 1972. The different provisions in the Social Security Act authorizing services were consolidated into a new title XX, enacted in 1974, which authorized additional funds beyond the ceiling for training. The original ceiling of $2.5 billion was raised several times, and, in fiscal year 1981, had reached a level of $2.9 billion, plus $16 million for the territories and $75 million for training. This ceiling was scheduled to rise further until it reached $3.3 billion in fiscal year 1985.

As it operated prior to the enactment of the Omnibus Budget Reconciliation Act of 1981, title XX provided 75 percent Federal financing for most social services, except family planning which was 90 percent federally funded and certain day care services which received 100 percent Federal funds. Training also was matched at a 75-percent Federal rate. The law required at least half of each State's Federal allotment to be used for services to recipients of aid to families with dependent children (AFDC), supplemental security income (SSI), or medicaid. The remaining funds could be used to provide services to anyone whose income did not exceed 115 percent of the State's median income. Fees were mandatory for individuals with income between 80 percent and 115 percent of State median income. States also had to follow a specified planning and public participation process.

In 1981, Congress eliminated a number of restrictions in title XX when it created the social services block grant under the Omnibus Budget Reconciliation Act. In doing so, Congress granted the Reagan administration added flexibility to transfer maximum decisionmaking authority to State governments. For example, under the SSBG, States are no longer required to provide a minimum level of services to AFDC, SSI, or medicaid recipients, nor are Federal income eligibility limits imposed. Under these new provisions States are free to design their own mix of services and establish their own eligibility criteria. Further, non-Federal matching requirements were eliminated. Federal standards for services, particularly for child day care, also were dropped.

The Reconciliation Act set the following authorization levels for the SSBG: $2.4 billion in fiscal year 1982, $2.45 billion in fiscal year 1983, $2.5 billion in fiscal year 1984, $2.6 billion in fiscal year 1985, and $2.7 billion in fiscal year 1986 and beyond. The program is permanently authorized. States are entitled to receive a share of the total according to their population size. Because the program is an entitlement to States with a nationwide ceiling, a decrease in appropriations would require a lowering of the ceiling levels contained in the authorizing legislation.

### 1. LEGISLATIVE ACTIVITIES IN 1983

The Reagan administration attempted unsuccessfully in fiscal year 1983 to lower the ceiling for the SSBG from $2.45 to $1.974 billion. In the fiscal year 1984 budget request, the administration originally requested the fully authorized amount of $2.5 billion. However, it subsequently lowered its fiscal year 1984 request for the SSBG to $2.44 billion. At the same time, the White House proposed to terminate all funding for two related programs, the community service block grant and the work incentive program, and allow States to continue these activities using SSBG funds. No corresponding funding increase in the SSBG was proposed, however. The 1983 continuing resolution (Public Law 97-377) funded the SSBG program at the authorized level of $2.45 billion through September 30, 1983.

In addition, during fiscal year 1983, an emergency jobs-creation supplemental appropriation was passed by the Congress and signed by the President (Public Law 98-8), providing an additional $225 million for the SSBG. Of these additional funds for the program, half were distributed according to the regular SSBG formula (relative population size) and half were distributed according to the State's rate of unemployment.

On September 22, 1983, the House passed its fiscal year 1984 Labor-HHS appropriation bill (H.R. 3913), containing $2.5 billion for the SSBG. The Senate passed its version of H.R. 3913 on October 4 and included $2.675 billion, which was the same amount provided in fiscal year 1983 (i.e., the regular appropriation of $2.45 billion and the jobs bill supplemental of $225 million). President Reagan signed the final version of H.R. 3913 into law on October 31 (Public Law 98-139), which contained $2.675 billion for the SSBG for fiscal year 1984.

In a related funding development, the House passed an unemployment compensation bill (H.R. 3929) on September 29. This bill would have permanently increased the SSBG authorization level to $2.8 billion. Additionally, it provided that during fiscal years 1985 and 1986, $100 million of this amount would have to be spent on unemployment-related activities and targeted to high unemployment areas within the State. The version passed by the Senate on September 30 would have increased the SSBG to $2.7 billion in fiscal year 1984 only. House-Senate conferees eventually agreed to a permanent increase for the SSBG to $2.7 billion, with no targeting on high unemployment areas. However, the conferees stated that they intended States to use some funds for unemployment-related activities and to allocate some funds to areas with high unemployment rates. President Reagan signed this measure into law on October 24 (Public Law 98-135). Although this law provides for an increase in the authorization level, there has been no corresponding congressional action to increase the fiscal year 1984 appropriation level at the present time.

TABLE 1.—*Fiscal year 1983 Federal allotments to States for social services: Title XX block grants*

| | |
|---|---|
| Alabama | $41,843,292 |
| Alaska | 4,302,652 |
| Arizona | 29,236,521 |
| Arkansas | 24,589,657 |
| California | 254,598,682 |
| Colorado | 31,075,905 |
| Connecticut | 33,431,607 |
| Delaware | 6,400,195 |
| District of Columbia | 6,862,730 |
| Florida | 104,769,579 |
| Georgia | 58,774,228 |
| Guam | 422,414 |
| Hawaii | 10,380,148 |
| Idaho | 10,154,259 |
| Illinois | 122,819,205 |
| Indiana | 59,053,900 |
| Iowa | 31,334,064 |
| Kansas | 25,417,917 |
| Kentucky | 39,380,023 |
| Louisiana | 45,220,874 |
| Maine | 12,101,209 |
| Maryland | 45,349,953 |
| Massachusetts | 61,710,788 |
| Michigan | 99,584,883 |
| Minnesota | 43,854,782 |
| Mississippi | 27,117,465 |
| Missouri | 52,890,351 |
| Montana | 8,465,468 |
| Nebraska | 16,887,910 |
| Nevada | 8,594,548 |
| New Hampshire | 9,906,856 |
| New Jersey | 79,211,825 |
| New Mexico | 13,983,619 |
| New York | 188,854,158 |
| North Carolina | 63,184,448 |
| North Dakota | 7,024,080 |
| Northern Marianas | 84,483 |
| Ohio | 116,139,337 |
| Oklahoma | 32,538,807 |
| Oregon | 28,322,208 |
| Pennsylvania | 127,648,932 |
| Puerto Rico | 12,672,414 |
| Rhode Island | 10,186,529 |
| South Carolina | 33,549,930 |
| South Dakota | 7,422,075 |
| Tennessee | 49,383,690 |
| Texas | 153,045,336 |
| Utah | 15,715,437 |
| Vermont | 5,496,638 |
| Virgin Islands | 422,414 |
| Virginia | 57,504,946 |
| Washington | 44,424,883 |
| West Virginia | 20,975,429 |
| Wisconsin | 50,609,946 |
| Wyoming | 5,066,373 |
| Total | 2,450,000,000 |

## TABLE 2.—FISCAL YEAR 1983 ADDITIONAL FEDERAL ALLOTMENTS TO STATES FOR TITLE XX SOCIAL SERVICES BLOCK GRANTS, PUBLIC LAW 98-8

| | One-third based upon unemployed individuals in all States | One-sixth based upon unemployed individuals in long-term unemployment States | One-half based upon provisions of section 2003 of the Social Security Act | Total |
|---|---|---|---|---|
| Alabama | $1,692,032 | $1,393,585 | $1,922,108 | $5,008,725 |
| Alaska | 149,304 | NA | 197,647 | 346,951 |
| Arizona | 874,092 | 719,492 | 1,343,005 | 2,938,589 |
| Arkansas | 654,614 | 538,832 | 1,129,548 | 2,322,994 |
| California | 8,459,700 | 6,963,432 | 11,695,215 | 27,118,327 |
| Colorado | 881,692 | NA | 1,427,499 | 2,309,191 |
| Connecticut | 774,697 | NA | 1,535,710 | 2,310,407 |
| Delaware | 142,918 | NA | 294,000 | 436,918 |
| District of Columbia | 191,321 | 157,482 | 315,246 | 664,049 |
| Florida | 2,942,042 | NA | 4,812,683 | 7,754,725 |
| Georgia | 1,269,085 | NA | 2,699,846 | 3,968,931 |
| Guam | NA | NA | NA | NA |
| Hawaii | 151,362 | NA | 476,822 | 628,184 |
| Idaho | 331,307 | NA | 466,444 | 797,751 |
| Illinois | 4,459,879 | 3,670,895 | 5,841,806 | 13,772,382 |
| Indiana | 2,109,207 | 1,736,152 | 2,712,693 | 6,558,052 |
| Iowa | 897,801 | NA | 1,439,358 | 2,337,159 |
| Kansas | 531,155 | NA | 1,167,595 | 1,698,750 |
| Kentucky | 1,162,089 | 956,550 | 1,808,958 | 3,927,595 |
| Louisiana | 1,203,258 | 990,437 | 2,077,260 | 4,270,955 |
| Maine | 291,401 | NA | 555,879 | 847,280 |
| Maryland | 1,121,758 | NA | 2,083,190 | 3,204,948 |
| Massachusetts | 1,522,357 | NA | 2,834,739 | 4,357,096 |
| Michigan | 4,275,580 | 3,519,358 | 4,574,519 | 12,369,457 |
| Minnesota | 1,285,901 | NA | 2,014,508 | 3,300,409 |
| Mississippi | 741,948 | 610,720 | 1,245,664 | 2,598,332 |
| Missouri | 1,421,586 | NA | 2,429,565 | 3,851,151 |
| Montana | 237,411 | NA | 388,888 | 626,279 |
| Nebraska | 363,596 | NA | 775,761 | 1,139,357 |
| Nevada | 352,544 | 290,189 | 394,798 | 1,037,531 |
| New Hampshire | 243,677 | NA | 455,080 | 698,757 |
| New Jersey | 1,897,045 | NA | 3,638,665 | 5,535,710 |
| New Mexico | 369,573 | 304,206 | 642,350 | 1,316,129 |
| New York | 4,455,548 | NA | 8,675,182 | 13,130,730 |
| North Carolina | 1,704,007 | NA | 2,902,434 | 4,606,441 |
| North Dakota | 167,170 | NA | 322,658 | 489,828 |
| North Mariana Islands | NA | NA | NA | NA |
| Ohio | 4,356,418 | 3,585,898 | 5,334,963 | 13,277,279 |
| Oklahoma | 644,016 | NA | 1,494,699 | 2,138,715 |
| Oregon | 1,045,588 | 860,654 | 1,301,005 | 3,207,247 |
| Pennsylvania | 4,747,038 | 3,904,430 | 5,863,666 | 14,518,134 |
| Puerto Rico | 1,360,633 | 1,119,978 | 581,897 | 3,062,508 |
| Rhode Island | 347,658 | 286,168 | 467,926 | 1,101,753 |
| South Carolina | 1,009,766 | 831,168 | 1,541,148 | 3,382,079 |
| South Dakota | 142,192 | NA | 340,940 | 483,132 |
| Tennessee | 1,701,770 | 1,400,778 | 2,268,484 | 5,371,032 |
| Texas | 3,810,022 | NA | 7,030,272 | 10,840,294 |
| Utah | 331,433 | NA | 721,902 | 1,103,335 |
| Vermont | 123,010 | NA | 252,494 | 375,504 |
| Virgin Islands | NA | NA | NA | NA |
| Virginia | 1,415,396 | NA | 2,641,540 | 4,056,936 |
| Washington | 1,599,472 | 1,316,573 | 2,040,696 | 4,956,741 |
| West Virginia | 929,110 | 764,773 | 963,525 | 2,657,413 |
| Wisconsin | 1,913,728 | 1,575,245 | 2,324,812 | 5,613,783 |
| Wyoming | 143,296 | NA | 232,729 | 376,025 |
| Total | 75,000,000 | 37,500,000 | 112,500,000 | 225,000,000 |

## TABLE 3.—FISCAL YEAR 1984 FEDERAL ALLOTMENT TO STATES FOR SOCIAL SERVICES: TITLE XX BLOCK GRANTS

| Block grants | Column 1—authorization level, Public Law 98–135 | Column 2—authorization level, Public Law 98–139 |
|---|---|---|
| Alabama | $45,864,287 | $45,439,617 |
| Alaska | 4,824,122 | 4,779,455 |
| Arizona | 32,715,041 | 32,412,124 |
| Arkansas | 26,883,942 | 26,635,017 |
| California | 283,311,791 | 280,688,534 |
| Colorado | 34,717,287 | 34,395,830 |
| Connecticut | 36,696,114 | 36,356,335 |
| Delaware | 7,002,003 | 6,937,170 |
| District of Columbia | 7,388,401 | 7,319,990 |
| Florida | 119,233,095 | 118,129,085 |
| Georgia | 65,266,157 | 64,661,841 |
| Guam | 465,517 | 461,207 |
| Hawaii | 11,486,563 | 11,380,206 |
| Idaho | 11,228,964 | 11,124,992 |
| Illinois | 134,208,951 | 132,966,275 |
| Indiana | 64,025,000 | 63,432,176 |
| Iowa | 33,944,491 | 33,630,190 |
| Kansas | 27,902,628 | 27,644,271 |
| Kentucky | 42,878,483 | 42,481,460 |
| Louisiana | 50,442,520 | 49,975,459 |
| Maine | 13,266,335 | 13,143,499 |
| Maryland | 49,915,613 | 49,453,431 |
| Massachusetts | 67,596,255 | 66,970,364 |
| Minnesota | 47,936,786 | 47,492,927 |
| Mississippi | 29,635,566 | 29,361,163 |
| Missouri | 57,854,339 | 57,318,850 |
| Montana | 9,285,264 | 9,199,290 |
| Nebraska | 18,465,146 | 18,294,173 |
| Nevada | 9,894,134 | 9,802,521 |
| New Hampshire | 10,959,656 | 10,858,178 |
| New Jersey | 86,693,689 | 85,890,969 |
| New Mexico | 15,549,597 | 15,405,619 |
| New York | 206,102,419 | 204,194,064 |
| North Carolina | 69,703,880 | 69,058,474 |
| North Dakota | 7,704,545 | 7,633,207 |
| North Mariana Islands | 93,104 | 92,241 |
| Ohio | 126,235,097 | 125,066,253 |
| Oklahoma | 36,298,006 | 35,961,914 |
| Oregon | 31,040,649 | 30,753,236 |
| Pennsylvania | 138,997,945 | 137,710,926 |
| Puerto Rico | 13,965,517 | 13,836,207 |
| Rhode Island | 11,158,710 | 11,055,389 |
| South Carolina | 37,082,512 | 36,739,155 |
| South Dakota | 8,032,397 | 7,958,023 |
| Tennessee | 54,002,066 | 53,502,047 |
| Texas | 172,895,598 | 171,294,713 |
| Utah | 17,774,314 | 17,609,737 |
| Vermont | 6,041,862 | 5,985,918 |
| Virgin Islands | 465,517 | 481,207 |
| Virginia | 63,580,056 | 62,991,352 |
| Washington | 49,376,997 | 48,919,803 |
| West Virginia | 22,856,035 | 22,644,405 |
| Wisconsin | 55,524,241 | 55,010,127 |
| Wyoming | 5,760,846 | 5,707,504 |
| Total | 2,700,000,000 | 2,675,000,000 |

### 2. SSBG AND SERVICES TO THE ELDERLY

Because the Reconciliation Act and the Department of Health and Human Services have eliminated much of the reporting requirements previously included in the title XX program, very little information is available on how States have responded to both funding reductions and changes in the legislation. Limited information so far from HHS indicates that in fiscal year 1982 virtually all States provided at least four services: child day care, home-based services, protective and emergency services for children, and information and referral. Counseling, family planning, and adult protective and emergency services were offered in 47 States during fiscal year 1982. Adoption services were provided in 42 States and adult day care was provided in 38 States.

The role that the Social services block grant plays in providing services to the elderly has been a major concern to policymakers involved with the aging network. Supporters of the SSBG concept have noted that social services can be delivered more efficiently and effectively due to administrative savings and the simplification of Federal requirements. Critics, on the other hand, have opposed the block grant approach because of the broad discretion allowed to States and the loosening of Federal restrictions and targeting provisions that assure a certain level of services for vulnerable populations, including the elderly. In addition, they have noted that because of the reductions in SSBG funding from the fiscal year 1980 level, the future will be marked with uncertainty and increased competition between the elderly and nonelderly service populations for scarce social welfare resources.

Previously, title XX had been a major source of funding for community social services. Because programs funded under title XX were not age-specific, the extent of program participation on the part of the elderly was unknown. States had a great deal of flexibility in reporting under the program, and, as a result, it was difficult to identify the numbers of elderly served, as well as the type of services they received. The elimination of many of the reporting requirements under the social service block grant has made efforts to track services to the elderly even more difficult.

Various estimates have been made to calculate the amount of SSBG funding that goes to benefit the elderly. In 1981, the Office of Management and Budget noted that approximately 21 percent of the total title XX dollars went to services for the elderly. More recent information was obtained in a survey conducted by the Subcommittee on Human Services of the House Select Committee on Aging. The subcommittee initiated a 50-State survey of title XX administrators on the extent of social services block grant funds that are targeted for elderly services. Out a total of 45 States responding, the majority spent between 10 and 20 percent of their social service block grant funds for services to older adults, with a range of 4.5 to 40 percent. The survey noted that a number of States did not keep age-specific data.

In 1982, the National Data Base on Aging released the results of a comprehensive survey of State and area agencies on aging. Out of a total of 530 area agencies on aging responding to questions concerning funding, 36 percent indicated that they used some title XX moneys. Additionally, a review of the composite budgets of these agencies revealed that, on average, title XX funds comprised approximately 7 percent of their overall budgets. In July 1983, the National Data Base on Aging released a report on funding sources and expenditure patterns of State and area agencies based on an annual sample of these organizations. This more recent data showed that SSBG funds comprised approximately 6.3 percent of State units on aging budgets and 4 percent of area agencies budgets in 1982.

In addition to problems in determining funding amounts, little data exists on the national level indicating the extent to which title XX actually is coordinated with other programs, or the extent to which overlapping services are provided.

Some research has been conducted on coordination between title XX and the network of State and area agencies on aging authorized by the Older Americans Act. The Urban Institute reported in September 1978, that aging network involvement in social services decisionmaking increased after enactment of title XX, although State units on aging were far more active than area agencies. This involvement generally took the form of interagency agreements, participation in title XX advisory boards, exchange of plans and needs assessment materials, negotiating purchase-of-service contracts, and attending public hearings. The Urban Institute also noted, however, that States too often viewed interagency agreements as the end of the coordinative process, rather than the beginning. The mere existence of these agreements did not guarantee their implementation and often gave the illusion of coordination without the reality. Nonetheless, the Urban Institute found that where States and area agencies on aging played a role in the title XX process, services for the elderly tended to expand.

## B. COMMUNITY SERVICES BLOCK GRANT

The Community Services Administration, which, in 1981, was abolished and replaced by the community service block grant (CSBG), was itself the successor in 1975 to the Office of Economic Opportunity (OEO). Launched in 1964, OEO became the centerpiece of President Lyndon Johnson's War on poverty. Deriving its authority from the Economic Opportunity Act of 1964, the Community Services Administration (CSA) was charged with the responsibilities to aid low-income individuals in all facets of their lives.

As part of its overall mandate to assure greater self-sufficiency for the elderly poor, CSA was instrumental in developing programs that assured access for older individuals to existing health, welfare, employment, housing, legal, consumer, education, and other services. In the beginning, the major CSA programs providing assistance to the elderly poor were local initiative programs carried out by a network of over 850 community action agencies, senior opportunity and services programs, and community food and nutrition programs. Generally, programs designed to meet the needs of the elderly poor in local communities were carried out through a well-defined advocacy strategy which attempted to better integrate services at the State level and at the point of delivery. In essence then, CSA's central function was to garner assistance from a variety of service-providing entities, and to represent the unique interests of the poor as they were affected by national policy.

During the 17-year history of OEO/CSA, numerous antipoverty programs were begun and spun off to other Federal agencies, including head start, legal services, low-income energy assistance and weatherization. The OEO budget peaked in fiscal years 1969 and 1970 with annual funding in those years of $1.9 billion. The funding then steadily declined until CSA's last year of existence in fiscal year 1981, when appropriations were $526.4 million.

In 1981, the Reagan administration proposed elimination of CSA and transfer of its functions into a block grant as part of an overall effort to eliminate categorical programs and reduce Federal overhead. Further, CSA had been criticized by the General Accounting Office and congressional oversight committees as inefficient and poorly administered. Many in Congress, however, opposed the complete elimination of this specific antipoverty program. As a result, CSA activities were continued in a separate CSBG, rather than being folded into a larger SSBG as proposed by the administration.

The Omnibus Budget Reconciliation Act of 1981 authorized the CSBG through fiscal year 1986 at an annual level of $389.5 million. The program is administered by a newly created Office of Community Services within the Department of Health and Human Services. In general, the legislation required that funds made available under the CSBG be passed through to existing community action programs that had previously been funded by the Community Services Administration. Additionally, the Secretary was permitted to reserve up to 9 percent of appropriations each year for discretionary use.

Since States had not played a major role in antipoverty activities while the Community Service Administration was alive, the Reconciliation Act offered States the option of not administering the new community services block grant during fiscal year 1982. Instead the Department of Health and Human Services would continue to fund the existing CSA grantees in those States, until the States themselves were prepared to take over the program. States which did opt to administer the block grant in fiscal year 1982 were required to use at least 90 percent of their allotments to fund community action agencies (CAA's) and other prior CSA grantees. In the Reconciliation Act, this 90-percent passthrough requirement only applied during fiscal year 1982. However, in the first and second continuing appropriations resolutions for fiscal year 1983 (Public Laws 97-276 and 97-377), Congress extended the 90-percent passthrough requirement for all of fiscal year 1983, except for States in which at least 45 percent of the counties were not served by an existing CAA. The four States which qualified for this exemption were Utah, Wyoming, Colorado, and Nevada. For fiscal year 1984, as agreed to in the Labor, HHS appropriations bill, the House and Senate again have endorsed continuation of this passthrough requirement, except for the four waiver States.

### 1. LEGISLATIVE ACTIVITIES DURING 1983

For fiscal year 1983, CSBG programs were funded under the authority of a continuing resolution (Public Law 97-377) at a level of

$360.5 million. Of appropriations provided for the CSBG and related programs at the beginning of fiscal year 1983, HHS allocated $316.7 million as block grants to States and used $31.3 million for discretionary projects. These projects included funding for community economic development, rural housing, migrants and seasonal farmworker assistance, and the national youth sports program. In addition, $6.3 million was used for Federal administration of the block grant, and $6.2 was allocated for remaining CSA closeout activities.

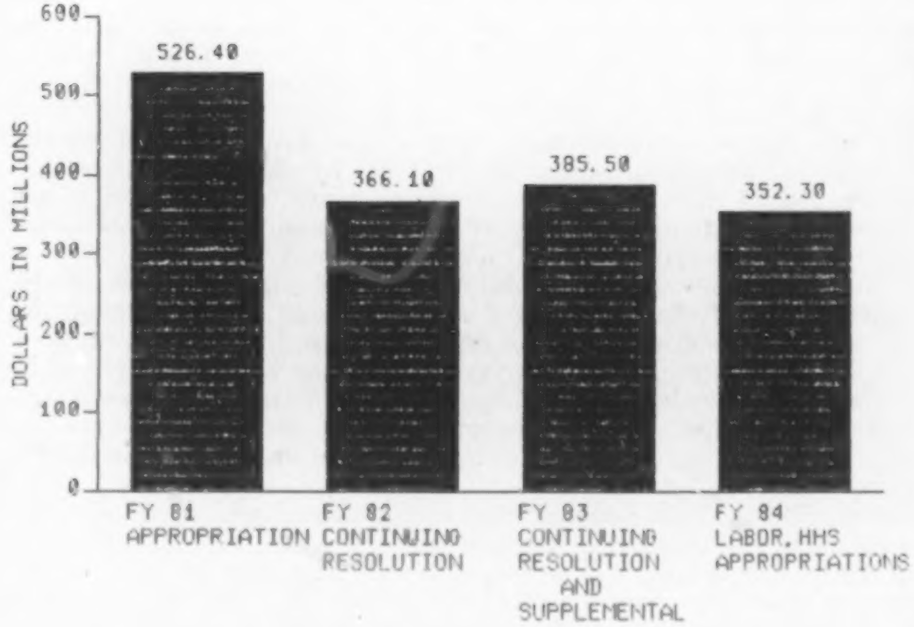
In addition to the regular appropriations, an emergency jobs-creation supplemental appropriation (Public Law 98–8), passed by the Congress and signed by the President on March 24, increased the CSBG budget for fiscal year 1983 by $25 million. Half of these new funds were allocated to States according to the regular CSBG formula (based on how much States received from CSA in fiscal year 1981), and the remaining funds were distributed according to State unemployment rates.

In the fiscal year 1984 budget proposal, the Reagan administration requested no funding for the community services block grant. Instead, the administration proposed that States use other sources of funding for antipoverty programs, particularly funds provided under the social services block grant. In justifying this phaseout and suggesting funding through the SSBG, the administration maintained that States would gain greater flexibility, because the SSBG contained fewer restrictions, and as such, States would be able to develop the mix of services and activities which were most appropriate to the unque social and economic needs of their residents.

On September 22, the House approved H.R. 3913 (the Labor, HHS, Education, and related agencies appropriations bill), which contained $351 million for the CSBG. Included in this total was $3 million for administrative activities, which would maintain Office of Community Service (OCS) staffing at 55 full-time positions. The Senate passed its version on H.R. 3913 on October 4 and included $377.3 million for the CSBG. Of this amount, $4.3 million would be earmarked for administrative costs and would maintain OCS staffing at 70 full-time positions. Because of the administration's efforts to limit the size of the Federal Government through reduction-in-force policies, both Houses of Congress were concerned that efforts be maintained to insure the availability of adequate assistance to States in the management and administration of the CSBG. Thus, these specific allocations for programs administration were included in the appropriations bill. Congress passed the final version of H.R. 3913 on October 20, containing $352.3 million for the CSBG and related activities. Of this amount, $4.3 million is to be used for program support, providing 70 full-time slots for OCS. President Reagan signed the bill into law on October 31 (Public Law 98–139).

CHART 1

COMMUNITY SERVICES BLOCK GRANTS
(FUNDING) FY1981-1984



## 2. Services for the Elderly Under CSBG

As with the social services block grant, reporting requirements under the community services block grant are minimal. As a result, very little information is available at the Federal level regarding State use of block grant funds. When the block grants were implemented, many of the requirements for data collection previously mandated and maintained under the Community Services Administration were eliminated. States were given broad flexibility in designing their own systems, plans, and the type of information they would collect under the grant.

Because of the 90 percent passthrough requirement, most grantees (usually CAA's) which existed during the last year of CSA are still being funded under the block grant. From the very beginning, these local community action agencies were involved in providing a range of services which benefited older persons. Programs such as weatherization, employment opportunities, emergency energy assistance, senior centers, and transportation were among those that were initiated and provided to the needy elderly by these organizations. State officials and local CAA administrators have indicated that CSBG funds are utilized to continue many of these initiatives, and also help maintain the general administrative operations of these local agencies. Thus, the funds permit the CAA's to mobilize other Federal resources in order to continue to provide programs directed at assisting low-income individuals.

## C. TRANSPORTATION

Transportation is the vital connecting link between home and community. For the elderly and nonelderly alike, adequate transportation is necessary for the fulfillment of most basic needs; maintaining relations with friends and family, commuting to work, grocery shopping, and engaging in social and recreational activities.

Housing, medical, financial, and social services are useful only to the extent that transportation can make them accessible to those in need. Transportation, then, serves both human and economic needs. It can enrich an older person's life by expanding opportunities for social interaction and community involvement, and it can support the individual's capacity for independent living, thus reducing or eliminating the need for institutional care.

The automobile is the primary means of transportation in the United States for both younger and older age groups, accounting for more than 80 percent of all personal trips, including excursions by automobile, public transportation, walking, bicycling, and other modes. The number of carowners declines dramatically in the upper age groups, primarily because income levels for most of the elderly population do not make ownership of an automobile affordable.[1]

According to the Federal Highway Administration, there were approximately 16 million licensed drivers age 65 and over in 1982. However, according to a 1974 survey by the U.S. Bureau of the Census, approximately 4 out of 10 persons age 65 and older who were heads of households did not own an automobile, a figure twice that of any other age group.

Access to transportation for the rural elderly is an even greater barrier. According to the report issued in 1979 by the National Strategy Conference on Improving Service Delivery to the Rual Elderly, nonurban elderly rely more heavily on transportation services, yet are losing access to transportation systems faster than urban residents. This loss of access is due in part to the combined effects of decreases in funding for transportation systems in general and the rising cost of fuel. The report also stated that only 1.4 percent of the 20,000 areas with populations of less than 50,000 still have public transit systems. Additionally, the results of a survey (on 192 predominantly rural counties) presented at the conference noted that only 2 percent had a rail terminal, 4 percent contained an airport offering commercial airline or commuter air service, and 3 percent had an intercity bus terminal. The problem is more severe in some Western States where isolated counties are located more than 300 to 500 miles from the nearest passenger transportation facility.

The House Select Committee on Aging released a report in December 1983 which reviewed differences between urban and rural elderly, and highlighted transportation as one of the major barriers. The report noted that rural elderly persons utilize less public transportation because their incomes are typically too low to purchase transportation services and they often live in areas not served by public transit systems. Further, the physical design and service features of public transportation frequently discourage participation by the elderly.[2]

---

[1] National Strategy Conference on Improving Service Delivery to the Rural Elderly. Improving Services for the Rural Elderly. Summary Report and Recommendations, Des Moines, Iowa, Jan. 28 to Feb. 2, 1979. pp. 7-8.

Federal transportation policy has not recognized the specialized needs of rural elderly. During the 1981 White House Conference on Aging, recommendations that supported improved rural transportation for the elderly were proposed. A Mini-Conference on Transporation for the Aging that preceded the general Conference recommended that State transportation agencies play a central role in developing responsive rural systems, with implementation for such a system initiated at the local level. The Conference also recommended greater citizen participation at the policymaking level as well as at the advisory and implementation levels of transportation programs. Other recommendations made by the Mini-Conference on Transportation for the Aging included:

—More local flexibility and fewer restrictions in the use of funds at the local level so that funds could be more easily pooled and coordinated around existing transportation programs, especially within any Department of Health and Human Services.

—Careful monitoring of the implementation of section 504 regulations authorized by the U.S. Department of Transportation to insure that there is no net loss of mobility as "mainline" vehicles are made accessible to the elderly.

—Coordination of transit and other providers' services with human service agencies in order to effectively serve elderly with limited incomes.

### 1. Legislation and Programs

Most federally sponsored programs that provide assistance to the elderly and handicapped are administered by the Department of Health and Human Services (HHS) and the Department of Transportation (DOT).

The goal of the Department of Transportation programs under the Urban Mass Transit Act (UMTA) of 1964, is to subsidize, and favorably influence, the design of mass transit systems through discretionary funding of State and local projects. Under the Department of Health and Human Services, a number of programs can provide funding to support specialized transportation services to the elderly. These programs can include the Older Americans Act, the social services block grant, the community services block grant, and to a limited extent title XIX (medicaid) which will reimburse transportation costs of the elderly poor to medical facilities.

At the Federal level, four events in the development of legislative policy have influenced the current provision of transportation services to older people. They include the passage of the Older Americans Act, the Urban Mass Transit Act, the National Mass

---

[2] U.S. Congress. House. Select Committee on Aging. Status of the Rural Elderly (Review of the Reported Differences Between the Rural and Urban Elderly: Status, Needs, Services and Service Costs), Publication No. 98-397. pp. 225-226.

Transportation Assistance Act, and the Surface Transportation Assistance Act of 1978.

### (A) OLDER AMERICANS ACT

The passage of the Older Americans Act of 1965 (Public Law 89-73) has had a large impact on the development of transportation for older people. Title III of this act authorizes assistance for transportation programs for the elderly. It calls for the distribution of funds by formula to States for the purpose of planning and providing for supportive services, nutrition services, and multipurpose senior centers. The amendments of 1981 (Public Law 97-115) require that an "adequate portion" of funds for supportive services and senior centers must be spent in the categories of access services, including transportation.

### (B) URBAN MASS TRANSIT ACT

The passage of the 1970 amendments to the Urban Mass Transit Act of 1964, sections 16(a) and 16(b) (Public Law 91-453), marked the beginning of special efforts to plan, design, and set aside funds for the purpose of modifying transportation facilities so that they could effectively be used by elderly and handicapped persons. Section 16(b)(2) of the Urban Mass Transit Act sets aside 3.5 percent of the urban discretionary funds for capital grants to private nonprofit groups serving elderly and handicapped. A policy was recently issued which would allow private for-profit operators to participate in this program through lease arrangements with the private nonprofit associations who are the recipients of these funds.

### (C) NATIONAL MASS TRANSPORTATION ASSISTANCE ACT

The third significant legislative and policy decision in the last 10 years has been the National Mass Transportation Assistance Act of 1974 (Public Law 93-503), which amended the Urban Mass Transit Act of 1964. Section 5 and a newly established section 9 provide money to urban and nonurban areas in the country through block grants, and permit the money to be used for capital operating purchases, at the localities' discretion. Section 5 also contains the requirement that transit authorities allow half-fares for the elderly and handicapped during offpeak hours.

### (D) SURFACE TRANSPORTATION ASSISTANCE ACT

The fourth piece of major legislation that assists the elderly is section 18 of the Surface Transportation Assistance Act of 1978 (Public Law 95-599). Beginning with fiscal year 1979, funds became available at the Federal level to support public transportation program cost, both operating and capital for nonurbanized areas. Areas with population under 50,000 were eligible for section 18 funds.

## 2. SYSTEMS SERVING THE ELDERLY

In 1975, the Institute of Public Administration, in its report, "Transportation for Older Americans: The State of the Art," identified 920 transportation projects serving the elderly of which 314 could be identified by type of service.[3] Five basic service categories were identified as serving the elderly: Conventional public transit, typically fixed-route and schedule service; special systems, usually described as some form of dial-a-ride or demand-responsive system; coordinated systems encompassing both fixed-route and dial-a-ride attributes, frequently "route deviation" systems; taxi systems typically operating with some form of reduced or subsidized rate; and a range of volunteer-based programs, usually operated by the nonprofit providers. The dial-a-ride or demand-responsive systems in coordination with the taxi systems and the modified fixed-route systems (all of which represent forms of paratransit), accounted for almost 70 percent of service providers.[4]

## 3. SPECIALIZED SYSTEMS

Specialized transportation systems comprise the major provider currently serving the elderly, and most take the form of a demand-responsive or dial-a-ride system, typically providing door-to-door service and requiring an advance reservation (usually 24 hours). A 1980 Institute of Public Administration study suggests there has been a steady increase of these systems, particularly those funded under title III (and formerly title VII) of the Older Americans Act. Estimates indicate that in fiscal year 1975 there were about 2,000 transportation projects being supported either fully or partially under these two titles, and by 1979 the total appears to have increased to an estimated range of 2,800 to 3,200 projects.[5]

## 4. CONGRESSIONAL ACTION IN 1983

### (A) DEPARTMENT OF TRANSPORTATION REGULATIONS CONCERNING ACCESS

In recent years, there has been a great deal of debate about the Department of Transportation (DOT) regulations implementing section 504 of the Rehabilitation Act of 1973. In 1979, DOT promulgated regulations (40 CFR Part 27) to implement the act, which required, among other things, accessibility for all modes of transportation receiving public money within 30 years. Further provisions for providing interim accessibility services during transition would also be required.

DOT withdrew those regulations in 1981 after a court ruling by the U.S. Appellate Court of the District of Columbia. The court determined that the section 504 regulations placed onerous, affirmative burdens on local programs and exceeded DOT's authority.

In July 1981, DOT issued a final interim rule which deleted the mass transit requirements of the original regulations and instead substituted a new section requiring that grant recipients certify that special efforts were being made in their service area to provide transportation that handicapped persons could use. This interim rule would remain in effect only until permanent regulations could be adopted.

---

[3] Institute of Public Administration. Improving Transportation Services for Older Americans, sponsored by the Administration on Aging, September 1980. p. 25.

[4] Willis, Y. The Effects of the Administration's Interagency Agreement Strategy, Transportation for the Elderly and Handicapped: Programs and Practice, December 1978. pp. 7–10.

[5] Wozney, M., and J. Burkhardt. An Analysis of Continuation of Services, Funded Under Title III of the Older Americans Act of 1965. Department of Health and Human Services, Administration on Aging, 1980.

There was concern in Congress that the DOT interim rule did not insure adequate service for the handicapped and elderly persons. On January 27, 1983, Senator Cranston along with four members of the Senate Banking Committee (Senators Williams, Sarbanes, Dodd, and Riegle) requested the Comptroller General to conduct a survey of transit services under the interim regulation. The survey covered 84 transit systems in 33 States and the District of Columbia. The data was collected from the transit operators (in the context of a GAO survey). Results from the survey showed a sharp retreat from the provision of accessible transportation service.

The results of the GAO survey showed widespread deficiencies in paratransit services for handicapped persons, such as waiting lists, long advance notice requirements, priorities based on trip purpose, shorter hours and fewer days of service, denials of geographical area of service, and inaccessibility of paratransit vehicles.

During debate on the Surface Transportation Act of 1982, Senators Cranston and Riegle proposed an amendment to the act which directed the Department to change its approach to implementing section 504. The Cranston/Riegle amendment called for minimum criteria to be established for the provision of transportation services to elderly and handicapped individuals by recipients of Federal financial assistance. Additionally, the amendment required procedures for the Secretary to monitor recipients' compliance with the criteria so that organizations and groups representing handicapped and elderly individuals could be given adequate notice of an opportunity to comment on the proposed activities of recipients. The amendment was passed and included as part of the Surface Transportation Act of 1982.

In September 1983, DOT published in the Federal Register, a notice of proposed rulemaking on nondiscrimination in transportation services for the elderly and handicapped. Under the new proposed rule, recipients of Federal assistance for mass transportation may meet their obligations for service to elderly and handicapped persons by equipping 50 percent of their buses with wheelchairs lifts, establishing a paratransit or special service system, or using a mixed system that would combine elements of accessible bus and paratransit service. Whatever type of system is established, the system must, subject to a cost ceiling, meet the service criteria as set forth in section 317(c) of STAA of 1982. The criteria are that: The system must serve the same geographic area as the recipient's service for the general public, at the same time and at comparable fares; there cannot be waiting lists for eligibility, or restrictions, or priorities based on trip purpose; the waiting time for service must be reasonable, and the program should be developed through a public participation process.

### (B) DEPARTMENT OF TRANSPORTATION FUNDING

Section 16(b)(2) of the Urban Mass Transit Act of 1964 (UMTA), as amended, allows 3.5 percent of the discretionary grant program funding to be set aside for capital assistance grants to States, local agencies, and private nonprofit groups, for transit services to the elderly and handicapped. The Reagan budget requested $1.2 billion for the discretionary grant program in fiscal year 1984, a $5 million decrease from the fiscal year 1983 appropriation of $1.6 billion. The Department of Transportation appropriations bill (H.R. 3329) which became Public Law 98-78, appropriated $1.2 billion for the discretionary grant program for fiscal year 1984. Using the 3.5 percent set-aside from the discretionary grant program, section 16(b)(2) received a total of $56 million in 1983 and a total of $44 million for 1984.

As a result of the Surface Transportation Assistance Act of 1982 (STAA), the section 5 formula grant program for urban areas, established under UMTA, was replaced with a new formula grant program, section 9, which began in fiscal year 1983. The STAA of 1982 requires that 97 percent of the formula grant program funding be set aside for section 9 to distribute to cities with populations of 50,000 and over on a formula basis. Section 9 also carries over the requirement under section 5 which stated that transit authorities allow half-fares for the elderly and handicapped during offpeak hours. The Department of Transportation appropriations bill (H.R. 3329), appropriated $2.3 billion for the program in fiscal year 1984.

Section 18 of UMTA provides formula transit grants for capital and operating purposes in nonurban areas of 50,000 or less. This grant program was designed to expand access to transportation in rural areas, many of which have high proportions of elderly residents. The STAA of 1982 requires that 3 percent of the formula grant funds be set-aside for section 18 for nonurban grants. The Reagan budget did not request funds for this purpose in fiscal year 1984. However, Congress appropriated a total of $68 million for the program in fiscal year 1983, and a total $70 million in fiscal year 1984 (H.R. 3329).

TABLE 4.—1983 DEPARTMENT OF TRANSPORTATION APPROPRIATIONS

| | Fiscal year 1983 | Fiscal year 1984 |
|---|---|---|
| Discretionary grant program (total) | $1,606,000,000 | $1,200,000,000 |
| Section 16(b)2 [1] | 56,000,000 | 44,000,000 |
| Formula grant program (total) | 1,268,000,000 | 2,388,592,000 |
| Section 5/urban | 1,300,000,000 | (2) |
| Section 9/urban [3] | (2) | 2,318,000,000 |
| Section 18/nonurban (4) | 68,000,000 | 69,986,000 |

[1] 3.5 percent setaside of the discretionary grant program.
[2] Sec. 5 of the discretionary grant program was terminated as of fiscal year 1984 and replaced with the sec. 9 program.
[3] 97 percent of the formula grant program goes to sec. 9 for urban grant programs.
[4] 3 percent of the formula grant program goes to sec. 18 for urban grant programs.

## D. EDUCATION

The national interest in education in the United States is somewhat different from that of other governmental services and programs. In the United States, education is a State responsibility, a local function, and a Federal concern. The role of the Federal Government in education has been to insure equal educational oppportunity, to enhance the quality of education, and to address national priorities in training. The State and local governments have had primary responsibility in educating adults and older citizens, with some participation from the private sector.

The impetus for the development of many Federal and State education policies for older persons grew out of a paper prepared for the 1971 White House Conference on Aging which cited a hierarchy of educational needs for older people. These range from the need to acquire the basic skills necessary to function in society, to the need to engage in activities which are enjoyable and meaningful and which benefit other people.

The 1981 White House Conference on Aging report of the technical committee on creating an age-integrated society, "Implications for Educational Systems," noted that as our society ages at an accelerated rate, it must assess and redefine the teaching and learning roles of older people, assure a match between the needs of older citizens and the training of those who prepare to serve them, and redouble its efforts to create a better informed and more sensitive public. Further findings of the technical committee revealed that while there has been an encouraging increase in the number of educational programs for older adults, these programs have failed to meet the needs of many older persons.

## 1. Educational Opportunities for Older Adults

Education can be seen as a means of acquiring and improving skills for living one's later years fully, coping with personal and societal changes, being actively involved in community life, and utilizing available options. While there may be strong arguments for the importance of formal and informal education for older people, in reality, it has traditionally been a low priority. Public and private resources for the support of education have been directed primarily to the establishment and maintenance of programs for children and youth, including those of the traditional college ages.

### (A) OLDER AMERICANS ACT

The Older Americans Act Amendments of 1981 (Public Law 97-115) broadened the scope of activities under the act. Language concerning "education and training" was included in the act's declaration of objectives as allowable supportive services to be offered by area agencies on aging.

The 1981 amendments to the Older Americans Act also maintained education and training as a component under title IV. The Commissioner was provided the discretion to grant funds for model demonstration projects in the area of education and training. Primarily, these projects are designed to encourage the development of gerontological instructional programs at colleges and universities for the training of personnel who work for or on behalf of older people. The Commissioner is also authorized to award grants for the purpose of establishing or supporting multidisciplinary centers of gerontology. In fiscal year 1980, AoA funded six national policy centers. The Center on Leisure, Education, and Continuing Opportunities at the National Council on Aging received a grant to study educational policy for older adults. The objectives of the "block grant" were broadly defined and allowed NCOA to study a wide range of education programs, including State-supported higher education programs for older adults, and nonprofit community-based older adult education programs designed for all levels of educational experience. In 1981, AoA instituted a policy review of all six national policy centers under new, stricter guidelines. The NCOA center failed to meet the standards of the four-member review panel, and was not funded after fiscal year 1981.

While the amendments to the Older Americans Act allow for special consideration of education and training, title IV sustained a cut from the $40.5 million appropriated in fiscal year 1981 to an appropriated level of $22.2 million for 1982, and $22.1 million in 1983. (See chapter 17 for a complete discussion of title IV.)

### B ELDERHOSTEL

Elderhostel was inspired by the youth hostels and folk schools of Europe, and is based on the conviction that retirement and later life represents an opportunity to enjoy new experiences.

Elderhostels are short-term residential, campus-based educational programs offered to older people at modest cost. Each elderhostel institution is encouraged to create an educational experience which is distinctive, emphasizing the academic strengths of the institution and the unique extracurricular and social environment which characterizes the campus community. Courses are in the liberal arts and sciences tradition and presuppose no particular level of formal education on the part of the student. Most elderhostel programs deliberately avoid age-specific focus on the problems of aging. Since elderhostel does not grant credit, individuals often choose their courses based on a lifetime enthusiasm rather than experience in traditional study.

Elderhostel was founded in New Hampshire in 1975, and has rapidly become a major national movement of considerable significance. Five pioneer institutions served 200 participants in the summer of 1975. Since then, dramatically increasing numbers of older people have enrolled in elderhostel programs. In 1983, over 700 participating institutions in 50 States and Canada served 44,000 summer hostelers and over 12,000 hostelers in academic year programs. In addition, over 3,000 hostelers participate in programs in Scandinavia, France, Germany, the Netherlands, Italy, and Great Britain.

### (C) INTERGENERATIONAL PROGRAMS

Intergenerational programs in schools were introduced in the early 1970's in an effort to counter the trend toward an increasingly age-segregated society in which few opportunities exist for meaningful contact between older adults and youth. Initially, programs were designed and implemented with an emphasis toward providing the support, teaching, and caring that would enhance the learning and development of schoolchildren. Eventually, intergenerational school programs emerged as a viable means of enriching the lives of older persons as well. Today, there are more than 100 intergenerational school programs nationwide. Over 250,000 volunteers participate in grades kindergarten through 12th.

Intergenerational school programs range from informal and haphazard, to large, centrally organized programs reaching over several school districts. One such "model" program is the senior citizen school volunteer program (SCSVP) established at the University of Pittsburgh and part of the Generations Together consortium of intergenerational programs. SCSVP is a nonprofit independent program that contracts with individual school systems who have demonstrated an interest in developing or maintaining a school volunteer program. In 1982-83, SCSVP placed some 300 volunteers over age 55 in over 50 schools in western Pennsylvania.

Whatever the size or scope, intergenerational school programs contribute immeasurably toward improving older persons' self-esteem and life satisfaction. School volunteering provides an opportunity for older persons to develop meaningful relationships with children—and to cope with their own personal trauma, such as the death of a spouse or friend. These programs also allow children to develop a more positive view of older people and aging while benefiting from the social and academic experience of their older tutors.

The Federal role in promoting intergenerational school programs has expanded recently through a joint initiative launched by the Administration on Aging and the Administration for Children, Youth, and Families. Their effort consists of four major components: (1) Establishing an information bank of intergenerational programs across the country; (2) disseminating this information to organizations interested in establishing such programs; (3) working with professional organizations to stimulate interest; and (4) funding intergenerational demonstration projects.

### (D) HIGHER EDUCATION

Older persons bring insight, interest, and commitment to learning that can generate similar enthusiasm from younger classmates, and can add to the personal satisfaction of learning. A logical extension of the success of intergenerational school programs is the intergenerational classroom at the college level. A recent study found that younger students studying together with persons of their parents' and grandparents' age broadened their attitude toward older people beyond rigid stereotypes and were able to identify them as peers. This rebukes the myth that older students somehow take away learning opportunity from younger students, and indicates a growing need to think of older adults as a vital part of the college classroom. In response to this challenge, some colleges have designed continuing education programs to provide the flexibility and support older students often need when reentering college after several years.

The Ada Comstock scholar program at Smith College began in 1975 as a way to offer a traditional education to women older than undergraduates of traditional age. This program goes well beyond extension classes or night school by fully integrating older students into the academic and campus life at Smith. The only difference between the two groups of students is that, unlike other Smith undergraduates, Ada Comstock students are allowed to take as long as they need or want to complete their college requirements. The older students, in return, bring an added dimension and vitality to the classroom by sharing their broad-based life experiences and interest in learning.

For those older students who cannot afford the cost of a private college, some States are moving to reduce the cost of higher education for adults age 60 and over. Although policies differ from State to State, most offer full tuition waiver and allow participants to take regular courses for credit. Since only two States provide reimbursement to individual institutions for older adult students, the participating colleges must make substantial investments in terms of curricular emphasis and financial support toward meeting the needs of older students.

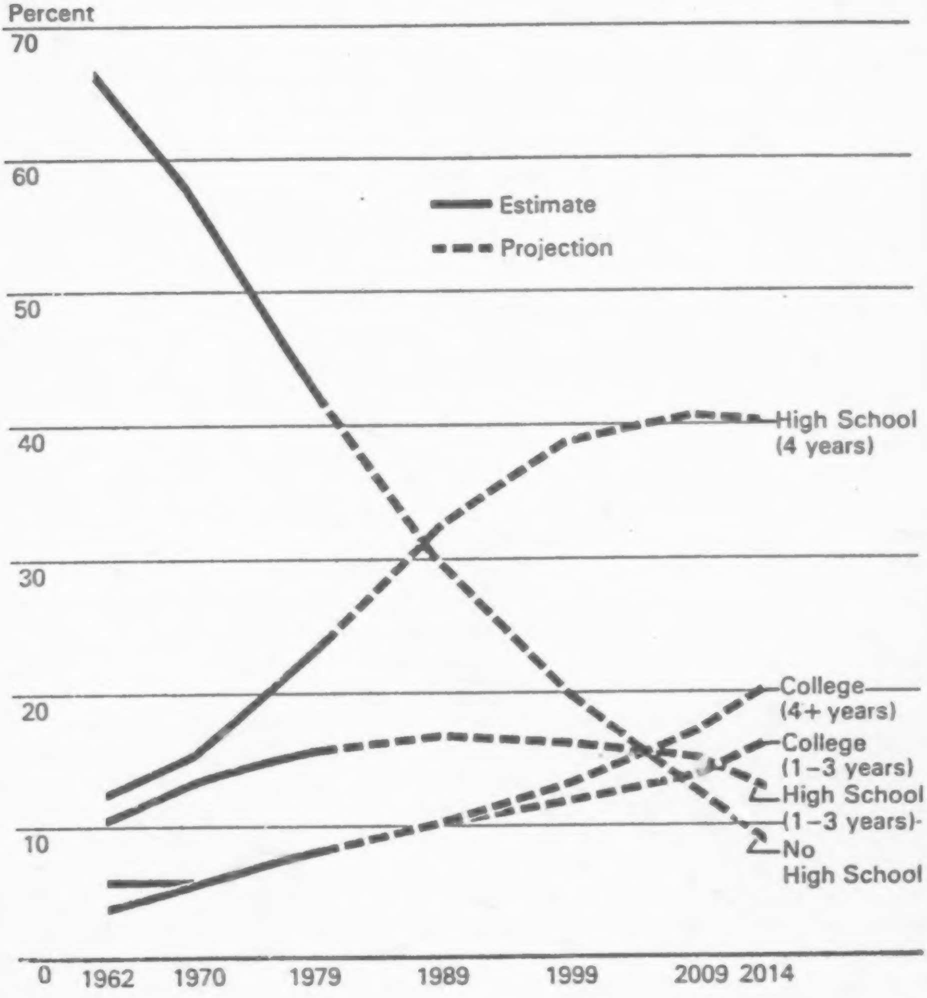
### (E) ADULT LITERACY

Literacy means more than just the ability to read and write. Literacy is more clearly defined as the essential knowledge and skills necessary for effective functioning in the home, community, and workplace. According to some estimates, as many as 27 million Americans, or one in five adults, function with great difficulty in our society. An additional 47 million can function but not proficiently. These figures mean that an astonishing 74 million Americans function in society at a marginal level or below.

Of all adults, the group 60 and older has the highest percentage of people who are functionally illiterate. Results of one study showed that 35 percent of adults 60 to 65 years of age lacked the skills and knowledge necessary to cope successfully in today's society. These figures reflect the direct correlation between educational attainment and literacy. As would be expected, there is a heavy concentration of older persons among adults 16 years and over with less than a high school education. Of those with less than a high school education, more than three-quarters of those 65 and over have not completed grade school. Although adult education programs exist throughout the country, most participants have a higher education level than the median for older Americans. Generally, educational systems in the United States have failed to address the needs of the older, illiterate adult. While older adults in the future will have higher levels of educational attainment (see chart 2), current education programs need to focus on the problems facing today's adult.

CHART 2

EDUCATIONAL ATTAINMENT OF THE ELDERLY: UNITED STATES, 1962-2014



Source: National Center for Education Statistics.

In response to the President's Commission on Excellence in Education Report concerning the quality of education in America, the Reagan administration made the elimination of illiteracy a major focus in 1983. The adult literacy initiative, sponsored by the Department of Education, is a largely promotional partnership with the private sector direction at: (1) Promoting a national awareness campaign; (2) establishing a literacy project for support at the State and local level; (3) promoting college credit and work-study assignments for literacy tutoring; and (4) establishing a corps of Federal employee literacy volunteers. The adult literacy initiative is currently unfunded.

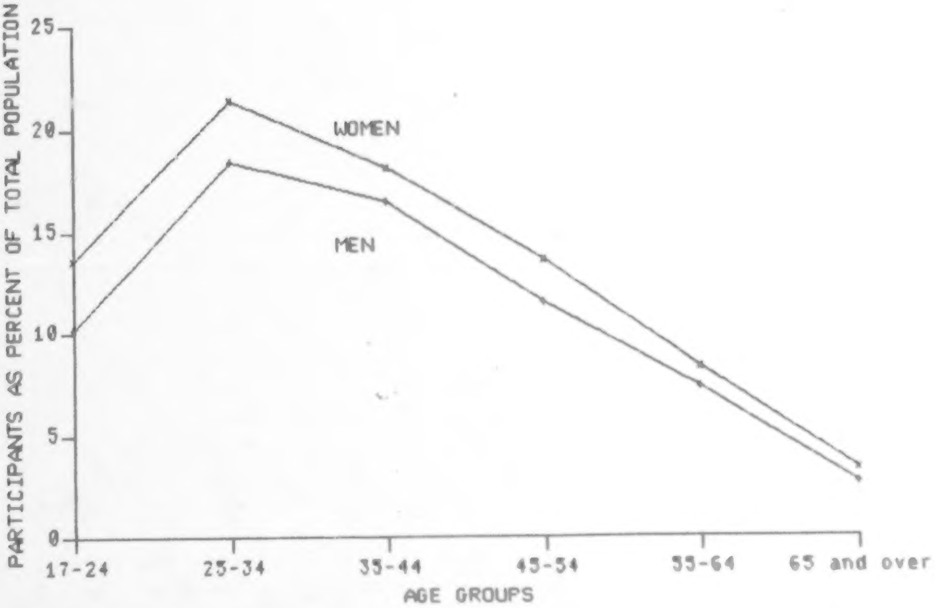
### (F) ADULT EDUCATION

The Department of Education is authorized under the Adult Education Act (Public Law 91-230) to provide funds for educational programs and support services benefiting all segments of the eligible adult population. The purpose of the act is to establish adult education programs that will enable adults 16 years and older to: (1) Acquire basic skills needed to function in society, and (2) assist them in continuing their education until completion of secondary level, if desired. Funds provided for adult education support State formula matching grants to combat functional illiteracy for adults over 16, and are distributed by a formula based on the number of adults in a State without high school diplomas who are not currently enrolled in school.

In 1977, a major change began in adult education enrollment. The enrollment of those aged 16 to 44 decreased while the enrollment of those aged 45 to 65 increased. A 1981 survey entitled "Participation in Adult Education" conducted by the National Center for Education Statistics revealed that 768,000 persons age 65 and older, or 3.1 percent of all older Americans, participated in educational activities. Although the majority of adult education participants are under 35 (see chart 3), this marked the highest number and proportion of older people involved in adult education ever recorded by the NCES. Even more dramatic—the number of persons 65 and older participating in adult education has almost tripled, growing at the average rate of 30 percent every 3 years compared to an average rate of 12 percent for adult participation of all ages.

CHART 3

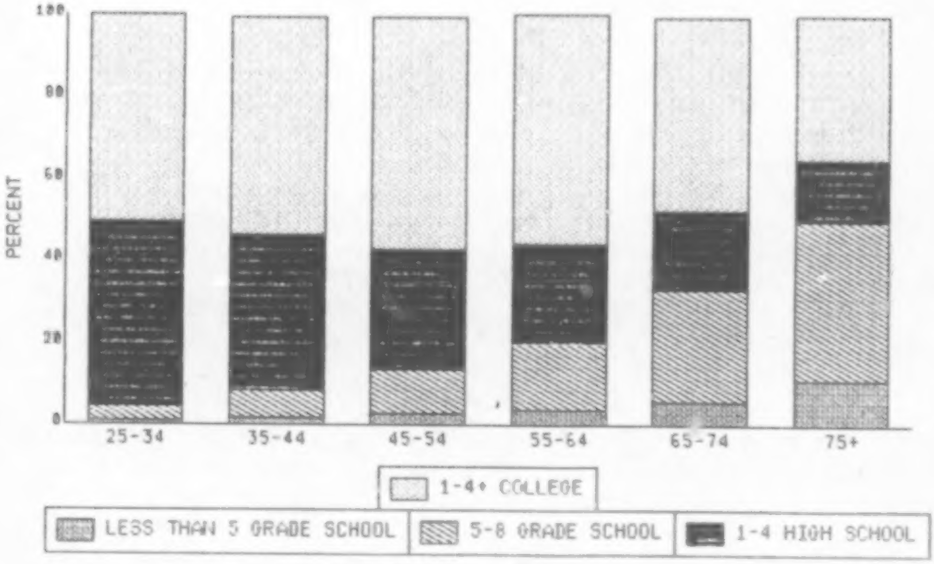
PARTICIPATION IN ADULT EDUCATION BY AGE AND SEX



Nevertheless, with less than 5 percent of the elderly population enrolled in an educational institute in 1981, older people continue to be underrepresented in education programs in relation to their proportion in the total U.S. adult population. This is due primarily to the fact that while older persons certainly have the ability to learn, the desire to learn is a function of educational experience. For example, the National Center for Educational Statistics reported in 1981 that the level of participation in adult education rose at each higher educational level from 2.2 percent of the total population with less than an eighth grade education to 31 percent with 5 years of college or more. A 1981 NCOA/Harris survey supports this correlation between years of schooling completed and participation in adult education. As chart 4 illustrates, educational attainment of the elderly is well below that of the younger population, although this fact will change as better educated cohorts enter the older age group.

CHART 4

EDUCATIONAL ATTAINMENT BY AGE
1982



Source: U.S. Bureau of the Census, Current Population Survey, 1982

The existence of special classes and programs geared to older adults is still relatively rare except in community senior centers. Most of the classes focus on self-enrichment and life-coping skills and are gradually shifting to educational programs on self-sufficiency. Few programs currently exist to meet the growing demand for the skills needed for volunteer or paid work later in life. As the median years of schooling for older adults increases, and older persons look to continued employment as a source of economic security, adult education programs may need to shift their emphasis from "personal interest" courses to include job-training skills.

## 2. Congressional Action During 1983

Under the Labor, HHS, Education appropriations bill for fiscal year 1984, Congress approved a funding level of $100 million for the adult education program—$5 million more than the amount appropriated in fiscal year 1983. In a bill introduced by Senator Hatch (S. 1059), the administration proposed to merge existing Federal vocational and adult education programs into a consolidated block grant program to States. Concern was raised, however, that this proposal ignored important fundamental differences between vocational education—which serves those adults who require retraining for employment, and adult education—which acts as a basis for learning in later life, and would only weaken these successful programs.

Under title I-B of the Higher Education Act of 1966, educational outreach programs were established and aimed at addressing the needs of underserved adults, including the elderly, whose previous educational experiences had acted as a barrier to lifelong learning. Both the continuing resolution for fiscal year 1982 and the Reagan budget for fiscal year 1983 provided no funding for this program. Although an authorization remains in place for educational outreach activities under the Omnibus Budget Reconciliation Act of 1981, the program was essentially phased out by the end of the 1982 fiscal year.

The Fund for the Improvement of Postsecondary Education (FIPSE) was authorized under the Educational Amendments Act of 1972 to improve postsecondary educational opportunities by providing assistance to educational institutions and agencies for a broad-based range of reforms and innovations. A major purpose of FIPSE is to address the problem of providing access and insuring successful completion of academic programs for so-called untraditional students—including older adults. The Labor, HHS, Education appropriation bill for fiscal year 1984 authorized a funding level for this program of over $11 million.

## 3. FUTURE TRENDS

In coming years, a growing number of older people with higher educational attainment than their parents and grandparents will create a demand for greater educational opportunities than exist today. Rapid technological change in our society is intensifying the need for lifelong learning, and is placing a greater emphasis on acquiring new job skills such as computer programing.

In order to adquately address the educational needs of older persons, greater attention needs to be devoted to providing the supportive services which can help older students enjoy successful learning experiences. Federal, State, local, and private sector initiatives need to focus on the types of educational programs most suitable for older people, and action needs to be taken to increase participation for those older persons with less education, especially the illiterate. With the "graying" of America, now seems the appropriate time to refocus our educational programs, and commit our resources to enhancing the educational opportunities of older persons.

# Part VI

# PERSONAL SAFETY OF THE ELDERLY: CRIME AND ACCIDENTAL FIRES

The personal safety of the elderly can be threatened in many ways, including intentional criminal attacks and accidental fires in their homes.

The fear of being victimized by criminals and the fear of death or of disfiguring and disabling injuries caused by accidental fires in their homes are matters of serious concern to elderly persons. Recent evidence suggests that, especially in major cities, assaults and purse-snatchings directed against older Americans are increasing, and the fear of criminal attack is likewise escalating—to the point in many areas where the opportunities and the lifestyles of the more physically vulnerable elderly are severely limited by this factor alone.

Similarly, older persons are more likely to be killed in home fires than younger persons. Yet home fire prevention devices, such as smoke detectors, have not been as widely installed in the homes of the elderly as in those of the population at large. In addition, the major cause of such death, fires started by cigarettes, has not been effectively addressed.

Fear of crime and its attendant victimization as well as vulnerability to death and injury from home fires are not necessary components of the aging process. As the following pages of this section indicate, the committee has focused its activities on understanding the exact nature of these problems and supporting the development of strategies effective in combating them.

# Chapter 21

# CRIME AND THE ELDERLY

## A. THE PROBLEM

Violent crime is a problem of significant magnitude in the United States. In 1982, according to the FBI's Uniform Crime Report, a violent crime occurred every 25 seconds in this country. Murders left the families and friends of over 21,000 persons devastated; 77,760 women suffered the degradation of forcible rape; over half a million people were robbed; 650,040 were victims of aggravated assault; and almost 3.5 million burglaries occurred. These crimes alone accounted for almost 5 million victims of violent crime. Each year, more than 40 million Americans are criminally victimized.

The U.S. Justice Department concludes that of the 26 million elderly in this country, about 182,000 will be victims of a violent crime this year. About 642,000 will suffer a theft. Another 1.5 million households will be the victims of larceny. Today's 26 million elderly in the United States—about 11 percent of the population—will grow to be some 17 percent of the population by the year 2000. Thus, we must recognize that we are clearly facing a problem of seriously growing dimensions for the elderly.

A 1981 Harris survey indicated that older persons are more concerned about the impact of crime on their lives than they are about their health, income, or most other social problems.[1] As a result, many seniors change their behavior out of fear of being victimized. Others limit their travel to avoid specific areas and restrict shopping activities to "safe times."

When older persons do fall victim to crime, the impact on their lives is likely to be greater than on other population groups. They are more likely to be injured, take longer to recover, and incur greater proportional losses to income. All ages are victimized, but such victimizing action has a particularly devastating effect on older Americans.

The elderly are easy prey for criminals, given their special vulnerabilities. About 60 percent live in urban areas, where there are more likely to be criminal elements active. Often, the elderly live in social isolation. Too often, they are unable to offer a defense to their attackers. Because they rarely have insurance or coverage through work, the financial impact of crime can be devastating on older victims. They often have to carry the full burden of the cost of the crime since many live on income from social security or some other form of fixed income. Emotionally, crime victimization of the elderly can be particularly devastating.

---

[1] "Aging in the Eighties: America in Transition." A survey concluded for the National Council on Aging by Louis Harris & Associates. November 1981.

## B. SENATE SPECIAL COMMITTEE ON AGING HEARINGS

Many of these problems were identified at two hearings conducted by the Senate Special Committee on Aging. The first, entitled "Older Americans: Fighting the Fear of Crime," was held on September 22, 1981, and the second, "Crime Against the Elderly," was held on July 6, 1983. The focus of these hearings was on the impact of crime and fear of crime on the lives of senior citizens and on constructive countermeasures that could be taken to prevent crime and to help crime victims. These measures include Federal support for victim compensation programs.

One of the witnesses at the hearing on "Older Americans Fighting the Fear of Crime" was Harriet Cunningham of Chester, Pa. Mrs. Cunningham was 77 at the time. She was the victim of a robber who snatched her shoulder bag and threw her to the ground. As a result of her fall, her shoulder blade and upper arm were shattered. Mrs. Cunningham's assailant was caught and convicted. He received a sentence of 2 to 4 years of incarceration, did his time, and was released. He paid his debt to society and was allowed to get on with his life. But what of his debt to Mrs. Cunningham?

In December 1982, Mrs. Cunningham died. According to the director of the senior safety project of the county where she resided, the robbery and its repercussions were contributing factors to her death. Mrs. Cunnningham never knew a day free from pain after her assault. She had extensive surgery on her shoulder, was hospitalized for 49 days and had outpatient therapy twice a week for more than 11 months. She tried several doctors, but never regained the use of her hand.

Because of the cost of these medical procedures, she had to give up her house and relocate. Mrs. Cunningham is but 1 of the more than 40 million Americans, many of them elderly, who are criminally victimized each year. She is one of many whose lives are shattered and fundamentally altered by random acts of violence and other crimes. As part of his sentence, Mrs. Cunningham's attacker was ordered to pay restitution of $126. Perhaps the court was correct in judging this to be reasonable based on the criminal's ability to pay, but this sum did not begin to reflect the financial impact of the crime on Mrs. Cunningham. Her medical bills were 100 times the amount of the restitution ordered.

Tragically, the Cunningham case was unusual not for the amount of restitution ordered, but for the fact that restitution was ordered at all. There will not be an order of restitution in most cases for the simple reason that in most cases the criminal will not be caught and successfully prosecuted. In fact, statistics reflect a successful resolution of less than 10 percent of all violent crimes.

## C. STATE VICTIM COMPENSATION PROGRAMS

To address this problem, 39 States, the District of Columbia, and the Virgin Islands have established victim's compensation programs. Unfortunately, according to Ronald Zweibel, president of the National Association of Victim's Compensation Programs, virtually all of these State crime victim's compensation programs are experiencing financial problems. As a result, many States are being forced to limit the amount of their award. Others do not advertise program availability for fear of depleting available resources or overtaxing numerically inadequate staff. In addition, because of funding problems in many States, victims may have to wait months before the compensation claim can be processed or sufficient revenue is generated to pay the claim. Mrs. Cunningham, for example, experienced a 6-month delay from the time her claim was filed in 1979 until payment was made. Victims who file a compensation claim in Pennsylvania today, according to the senior safety project, might not receive payment for more than 1 year.

Crime victim service programs are providing valuable assistance to thousands of elderly crime victims, but due to legal restrictions, inadequate funding, and general lack of public awareness, they are reaching only a small fraction of the Nation's crime victims, including the elderly.

## D. PRESIDENT'S TASK FORCE ON VICTIMS OF CRIME

In April 1982, President Reagan established the Task Force on Victims of Crime. In early 1983, the task force released their recommendations and final report. Though the recommendations did not focus on the specific problems of the elderly, the implications of these recommendations on the elderly are significant. The task force concluded that the treatment of victims by the criminal justice system has been careless and shameful. In many cases, the criminal received more consideration and fairer treatment than the victim. In the words of the task force: "Innocent victims of crime have been overlooked, their pleas for justice have gone unheeded, and their wounds—personal, emotional, and financial—have gone unattended."

One of the principal recommendations of the task force was a request for congressional action in enacting legislation to provide Federal funding to assist State crime victim compensation programs. The financial impact of crime can be severe. The impact on the elderly and poor is particularly severe since they often are without insurance or other means of regaining financial stability. While this problem is in part addressed by the restitution provisions of the Omnibus Victim's Protection Act passed last year, restitution can only be ordered if the criminal is caught and successfully prosecuted. Even in successful cases, restitution is not a complete remedy because the criminal does not always have the resources to provide relief if restitution is ordered.

The task force recommended that a crime victim's assistance fund be created and that it rely in part on Federal criminal fines, penalties, and forfeitures that currently are paid directly into the general fund. This recommendation reflects the concept that it is appropriate that criminals compensate their victims to the extent possible. This approach would also insure that the program established would be administratively self-sufficient.

The second basic recommendation of the task force dealt with the establishment of victim/witness assistance units. The task force recommended that Congress enact legislation to provide Federal funding, reasonably matched by local revenues, to assist in the operation of Federal, State, local, and private victim/witness agencies. The expressed view of the task force is that although the Federal Government should not fully subsidize these agencies, their efforts should be encouraged by financial assistance.

## E. CURRENT LEGISLATIVE INITIATIVES

### 1. Victims Compensation

On March 8, 1983, Senator Heinz, along with Senator Grassley, introduced S. 704, the Crime Victims Assistance Act, to provide financial support for State victim compensation programs and for Federal and State victims' and witness assistance programs. This support is essential if Congress is to fully implement the provisions of the Omnibus Victims Protection Act, as well as the recommendations of the President's Task Force on Victims of Crime.

Revenue for these purposes will be generated from sources related to the commission of the crime—such as increased fines, criminal forfeitures, improved collection procedures, and a specific, one-time compensation fee to be levied at the time of sentencing in all Federal crimes.

The purposes of this legislation would be accomplished without the creation of a new Federal bureaucracy, or an additional taxpayer burden. Administration of the fund, supported by fund revenues, would be lodged within the Department of Justice. Compensation funds would be distributed by the Attorney General to existing State programs based on a formula reflecting the proportion of the State's compensation activity to the national experience. These State programs, some operational for more than 15 years, minimally compensate for medical, counseling, and therapy expenses associated with victimization. Most programs also reimburse for lost wages, loss of support to dependents, and funeral expenses. Property losses are generally excluded.

There are only three preconditions to Federal support. States would only be eligible for Federal funds after their compensation programs have been operational for 1 year. The purpose of this qualification is to insure that the State has made an independent commitment to the program and to establish their level of activity. Participating States must agree to compensate all those victimized within the State's jurisdiction. Participating States must agree to include payment of psychological counseling as one of the basic elements of their compensation programs.

In instances of exclusive Federal jurisdiction, victims will be allowed to apply to any participating State for compensation. The resulting awards would be reimbursed dollar for dollar from the trust fund. Related administrative costs would be reimbursed by actual cost up to a cap of 25 percent of the compensation award. This bill has been referred to the Senate Committee on the Judiciary.

Based on the experience of the States with existing compensation programs, and 1981 crime statistics, an estimated $30 million will be required for compensation during 1984. State awards range anywhere from $500 in emergency funds to $50,000 in maximum benefits. State programs received 34,586 claims in fiscal year 1981. Over 17,000 awards were made, totaling $49 million. The average award was about $2,900. The funding elements described above would generate a minimum of $60 million to support and extend these efforts and for victims and witness assistance programs. They have the potential of generating more than $125 million for these purposes.

Under the provisions of this bill, half of the total collected will be made available to the States through the compensation fund. The remainder of the fund will be available to support State and Federal victim and witness assistance programs and to support administration of the program. This portion of the fund would support training of law enforcement officials; improving facilities for victims and witnesses; State and Federal victims and witness assistance programs; public awareness programs; and other related purposes. Funds generated in excess of those needed for compensation and victims/witness assistance programs would be transferred out of the Federal crime victim's assistance fund and into general revenues on a yearly basis.

Several hearings were held by the Senate during 1983 on victim compensation. The Special Committee on Aging held a hearing, "Crime Against the Elderly," on July 6, 1983, in Los Angeles, during which the need for Federal assistance for victim compensation programs was documented. The Senate Committee on Labor and Human Resources, Subcommittee on Aging also held a hearing entitled "Crime and the Elderly: Does Victim Compensation Work?" on June 28, 1983. In addition, the Senate Judiciary Committee, Subcommittee on Juvenile Justice held two hearings on victim compensation on September 20 and 28, 1983.

Other bills introduced in the Senate include: S. 1941, the Crime Victim's Assistance Fund, introduced by Senator Specter on October 6, 1983, which would establish a crime victim's assistance fund to provide Federal assistance to State and local programs to aid juvenile and adult victims of crime. This bill has been referred to the Senate Committee on the Judiciary, and S. 1644, the Sentencing Improvement Act of 1983, introduced by Senators Nunn and Armstrong on July 20, 1983, which describes restitution as an alternative form of punishment. The bill provides that in appropriate cases the court may, with due consideration of the defendant's resources, require him to pay the victim's medical expenses, repay the value or cost of damaged property or return that property. When no victims are ascertainable, the restitution will be paid into a special fund of the Treasury to be distributed on a quarterly basis to State victim compensation plans. This bill has been referred to the Senate Committee on the Judiciary.

In the House, four bills were introduced involving victim's compensation. H.R. 2978, the companion bill to S. 704, was introduced by Representative Fish on March 6, 1983. H.R. 2470, the Federal Victim's Compensation Trust Fund, introduced by Representative Russo on April 12, 1983, would amend the Internal Revenue Code of 1954 to provide that the excise tax from handguns will be transferred to a trust fund to be used for providing compensation to victims of crime. It was referred jointly to the House Committees on Judiciary and Ways and Means. Hearings were held on this bill by the Subcommittee on Select Revenue Measures of the Ways and Means Committee on April 18, 1983.

H.R. 2661, the Federal Criminal Victims and Witnesses Assistance Act, was introduced by Representative Russo on April 20, 1983. It would establish a Victim's Compensation Commission in the Department of Justice. This Commission would establish guidelines for the payment of compensation to victims of crime. It was referred to the Committee on the Judiciary. H.R. 3498, the Victims of Crime Act of 1983, introduced by Representative Rodino on June 30, 1983, would authorize the Attorney General to make grants to the chief executive of each State for the financial support of qualified crime victim assistance programs. It was referred to the Committee on the Judiciary.

The response of the administration to victim compensation legislation has been favorable. Last year, the President's Task Force on Victims of Crime strongly endorsed the concept of Federal assistance to State victim compensation programs. Lois H. Herrington, Assistant Attorney General and formerly chairman of the President's Task Force, stated publicly in September 1983, that the proposal of such legislation was under serious and careful consideration within the Department of Justice.

### 2. OTHER LEGISLATIVE INITIATIVES RELATING TO CRIMINAL VICTIMIZATION OF THE ELDERLY

In the Senate, S. 699 was introduced by Senator Kennedy on March 7, 1983. It would authorize the Secretary of Health and Human Services to make grants to States for projects designed to prevent domestic violence and to provide immediate shelter and other assistance for victims and dependents of victims of domestic violence. It would also establish a Federal Interagency Council on Domestic Violence and direct the Secretary to report to the President and Congress on the nature and incidence of abuse of elderly persons. This bill has been referred to the Senate Committee on Labor and Human Resources, Subcommittee on Family and Human Services.

In the House, numerous bills were introduced which impact on crime and the elderly. H.R. 73, introduced by Representative Biaggi on January 1, 1983, would authorize the Secretary of Health and Human Services to make grants to States for projects designed to prevent domestic violence and to provide immediate shelter and other assistance for victims and dependents of victims of domestic violence. It also would direct the Secretary to report to the President and Congress on the nature and incidence of abuse of elderly persons. It was referred to the House Committee on Education and Labor, Subcommittee on Select Education.

H.R. 314, introduced by Representative Roe on January 3, 1983, would amend the Omnibus Crime Control and Safe Streets Act of 1968 to add a requirement that the comprehensive State plan include attention to the special problems of prevention, treatment, and other aspects of crimes against the elderly. It was referred to the House Committee on the Judiciary, Subcommittee on Crime.

H.R. 1397, introduced by Representative Mikulski, on February 10, 1983, would authorize the Secretary of Health and Human

Services to make grants to States for projects designed to prevent domestic violence and to provide immediate shelter and other assistance for victims and dependents of victims of domestic violence. It would also establish a Federal Interagency Council on Domestic Violence and would direct the Secretary to report to the President and Congress on the nature and incidence of abuse of elderly persons. This bill was referred to the House Committee on Education and Labor, Subcommittee on Select Education.

H.R. 1920, introduced by Representative Solomon, on March 3, 1983, would amend the Federal Criminal Code to impose mandatory minimum sentences for committing violent felonies against individuals aged 65 or over. It was referred to the House Committee on the Judiciary, Subcommittee on Criminal Justice.

H.R. 2008, introduced on March 9, 1983, by Representative Collins, would amend the Federal Criminal Code to establish penalties for persons who assault an individual over age 62 and cause medical damages of more than $100 to be paid under medicare. It was referred to the House Committee on the Judiciary, Subcommittee on Criminal Justice.

H.R. 2175, introduced by Representative Hughes on March 17, 1983, would amend title I of the Omnibus Crime Control and Safe Street Act of 1968 to replace the Law Enforcement Assistance Administration and the Office of Justice Assistance, Research, and Statistics with a new Office of Justice Assistance. It would also authorize State and local governments to apply for emergency Federal law enforcement assistance.

H.R. 3833 introduced by Representative Oakar on August 4, 1983, would direct the Secretary of Health and Human Services to establish the National Center on Elder Abuse to develop and implement a program to provide assistance to nonprofit organizations and States in the prevention and treatment of elder abuse. It was jointly referred to the House Committee on Education and Labor, Subcommittee on Human Resources, and also the Committee on Energy and Commerce, Subcommittee on Health and the Environment.

House amendment No. 106 was introduced by Representative Walker on May 10, 1983, as an amendment to H.R. 2175. It added a new grant category to the bill to provide for programs which address the increase incidence of offenses committed against the elderly, including the resulting stress and fear. It was passed by the House of Representatives on the same day.

# Chapter 22

# HOME FIRE SAFETY

## A. THE PROBLEM OF HOME FIRE DEATHS

Each year, 750,000 home fires occur in the United States, resulting in 6,000 deaths. The United States per capita fire death rate is twice the average rate of other Western industrialized countries. This threat is especially dangerous to our Nation's 26 million senior citizens. Older persons are two to three times more likely than younger individuals to be victims of home fires.

One-third of all fire deaths are the result of fires started by cigarettes—far more than any other single cause. Cigarettes cause almost 2,000 residential fire deaths annually in the United States. Cigarette fires also cause approximately 3,800 annual reportable injuries, over $300 million in annual property loss, thousands of dollars in medical costs, significant losses in productivity, and untold human suffering. Every day, an average of 16 people are maimed, burned beyond recognition, or killed by cigarette-caused fires. An estimated 40 percent of those killed in cigarette fires were persons other than the smoker of the cigarette which caused the fire.

## B. PROPOSED PREVENTATIVE MEASURES TO REDUCE HOME FIRE DEATHS HIGHLIGHTED BY SPECIAL COMMITTEE ON AGING HEARING

Many of these deaths are preventable. Given the disproportionately high fire death rate of older Americans when compared to other age groups, greater home fire safety precautions are vitally necessary for our senior citizens. To explore the problem of older Americans dying in home fires, the Senate Special Committee on Aging held a hearing on July 28, 1983, entitled "Home Fire Deaths: A Preventable Tragedy." The purpose of the hearing was to explore the appropriate Federal role in reducing the tragedy of thousands of lives, especially those of the elderly, needlessly lost in home fires.

An expert witness from the National Fire Protection Association described the typical scenerio for the most common fatal fire in America:

> A cigarette is carelessly discarded, most often in upholstered furniture or bedding. It smolders unnoticed. The heat is trapped in the crevices of the furniture or folds of bedding and a fire starts. Other family members have often gone to bed in another part of the house. The alarm typically is given in the middle of the night by a neighbor or passerby who sees smoke or fire. The fire department

> arrives promptly, but too late to save the victims. Death is generally due to smoke and toxic gases rather than flames.
>
> If we prevent the ignition or the fatal consequences of this one fire scenario, that alone will have an enormous impact on fire fatalities. A solution to this fire scenario must be found. To prevent ignition means developing firesafe cigarettes. To reduce fatalities means early warnings when fires do start. In other words, that means smoke detectors.

Unfortunately, the Federal Government has not moved to effectively address these fire safety problems. No Federal agency currently has jurisdiction over the fire safety of the cigarette. Likewise, the Federal Government's role has been limited in the promotion of smoke detectors for the elderly. Further testimony focused upon these important fire prevention measures, namely: (1) The development of a "firesafe" cigarette—a cigarette with a reduced propensity to ignite home furnishings; and (2) installation of smoke detectors in the homes of the elderly.

### 1. Development of "Firesafe" Cigarettes

Cigarettes are designed not to self-extinguish but to keep burning as long as there is tobacco to burn. Because the vast majority of cigarette fires begin with the ignition of upholstered furniture and mattresses, a "firesafe" cigarette—a cigarette with a reduced propensity to ignite home furnishings—would result in fewer fires caused by cigarettes.

Tests by the National Bureau of Standards and the California Bureau of Home Furnishings indicate that such low ignition potential cigarettes can be produced. The tobacco industry, on the other hand, disputes the feasibility of developing such a cigarette despite the current marketing of at least two brands which have a low ignition potential. To resolve this controversy, witnesses at the committee's hearings suggested that a Federal study of the technical and economic feasibility of developing a "firesafe" cigarette should be legislatively mandated by Congress.

The American Medical Association, the American Association of Retired Persons, the National Fire Protection Association, the American Burn Association, the American Association of Public Health Physicians, the American Public Health Association, the International Association of Fire Chiefs, the National Volunteer Fire Council and other groups support congressional action on the "firesafe" cigarette.

### 2. Smoke Detectors

Testimony received at the hearing characterized smoke detectors as an "inexpensive and highly effective home fire prevention measure." Yet in 1980, while two-thirds of the population owned smoke detectors, less than one-third of those over 65 owned them.

It is estimated that a 40-percent drop in home fire deaths would be achieved if the use of smoke detectors were more widespread. The risk of dying from fire in a home where detectors are installed is less than half that of dying from fire in homes without the device. Smoke detectors are even more effective in protecting life when the fire is caused by a cigarette because of the smoldering time in such fires. Moreover, the same homes which run the greatest statistical risk of fire, those with annual family incomes of $15,000 or less, are those homes least likely to have smoke detectors.

Peter Dys, executive director of the Office of Aging of Lancaster County, Pa., testified on various proposals to foster installation of smoke detectors in the homes of older persons. These included funding through the Older Americans Act and the community services block grant program of the U.S. Department of Health and Human Services, and the community development block grant program of the U.S. Department of Housing and Urban Development. In addition, New York Fire Department's Manhattan Borough Commander Chief, Matthew J. Farrell, testified on New York City's use of community development block grant funding to install 50,000 smoke detectors in the homes of low-income elderly persons.

## C. CURRENT LEGISLATIVE INITIATIVES

### 1. "Firesafe" Cigarettes

In October 1983, Senator Heinz, along with Senators Danforth and Cranston, introduced the Cigarette Safety Study Act, S. 1935, which would establish a Federal interagency task force to study the technical and economic feasibility of developing "firesafe" cigarettes with a report on its findings due Congress in 2 years. The task force would include participation by the Department of Health and Human Services, the Consumer Product Safety Commission, the Federal Trade Commission, and the National Bureau of Standards of the Department of Commerce, as well as the tobacco industry. The task force would: (a) Develop a testing method of determining the ignition propensity of cigarettes and little cigars; (b) identify the different physical characteristics of cigarettes and little cigars which have an impact on the ignition of furnishings; (c) recommend criteria by which the propensity for cigarettes and little cigars to ignite upholstered furniture and mattresses may be rated; (d) recommend criteria for the manufacture of cigarettes and little cigars in a manner which will minimize the propensity of these items to ignite upholstered furniture and mattresses; (e) identify health consequences, if any, of implementing "firesafe" cigarettes criteria; and (f) analyze both the cost and benefits, to industry and to society, of "firesafe" cigarette criteria.

This report would give Congress and the executive branch the scientific, technical, and economic information necessary to develop policy on the tobacco industry's responsibility for and the government's role in modifying tobacco products to reduce fire deaths and injuries. The bill was referred to the Senate Committee on Governmental Affairs.

There are currently three bills before Congress that would require production of a low ignition potential cigarette. In the Senate, Senator Cranston introduced S. 51 on January 26, 1983, which would require persons who manufacture cigarettes or little cigars to meet performance standards prescribed by the Consumer

Product Safety Commission. S. 51 has been referred to the Senate Committee on Commerce, Science, and Transportation.

In the House, H.R. 1880 was introduced by Representative Moakley on March 3, 1983. This bill would authorize the Consumer Product Safety Commission to set performance standards insuring that cigarettes and little cigars do not ignite smoldering upholstered furniture and mattress fires. This bill was referred to the House Committee on Energy and Commerce, Subcommittee on Health and the Environment, which held a hearing on this bill on March 21, 1983.

H.R. 1456, introduced by Representative Jacobs on February 15, 1983, would prohibit manufacturers of cigarettes or little cigars from adding any substance which promotes the continued burning of such cigarette or little cigar if left unattended. This bill has not yet been reported from the House Committee on Energy and Commerce, Subcommittee on Health and the Environment.

### 2. SMOKE DETECTOR LEGISLATION

In the House, bills have been introduced to give tax credits for smoke detectors. H.R. 228, introduced by Representative Neal on January 13, 1983, would amend the Internal Revenue Code to allow an income tax credit for 50 percent of the cost of purchasing and installing fire detectors in the residence of any taxpayer. It was referred to the House Committee on Ways and Means. H.R. 3048, introduced by Representative Dreier on May 18, 1983, would amend the Internal Revenue Code to provide a refundable income tax credit equal to 15 percent of the purchase and installation price of a security device such as a smoke detector placed in a residence. It was referred to the House Committee on Ways and Means. H.R. 3352, introduced by Representative Porter on June 16, 1983, would amend the Internal Revenue Code to provide a refundable income tax credit equal to 15 percent of the purchase price of a security device including smoke detectors placed in a building or residence. It was referred to the House Committee on Ways and Means.

# Chapter 23

# CONSUMER FRAUDS AND DECEPTIONS

The over age-65 market is a lucrative source of consumer expenditures, worth well over $60 billion annually. This fact, combined with a number of age-related factors, such as fixed income levels and chronic health conditions, contribute to making the elderly the easiest targets for consumer frauds and deceptions.

Ironically, at the same time that older Americans as a cumulative market are growing in consumer power, as individuals many live close to the poverty line and have little in the way of disposable income. Consequently, crimes aimed at the elderly's pocketbooks far too frequently have particularly severe consequences for their victims.

In response to these factors, the Senate Special Committee on Aging in recent years has initiated a broad-based examination into consumer frauds and the elderly.

In 1981, the committee held a field hearing in Harrisburg, Pa., entitled "Frauds Against the Elderly." In 1982, the committee conducted a national survey of law enforcement and consumer protection specialists, designed to assess which frauds impact upon the elderly most frequently and most severely. Then, in 1983, the committee convened a hearing in Washington, D.C., entitled "Combating Frauds Against the Elderly." During this same year, committee members worked for the enactment of a major piece of antifraud legislation, Public Law 98-186, the Mail Order Consumer Protection Act of 1983.

## A. SURVEY ON CONSUMER PROBLEMS AND ECONOMIC FRAUDS AGAINST THE ELDERLY

As an outgrowth of the earlier hearings on this issue, Chairman Heinz directed the committee staff to conduct a national survey of consumer problems and economic frauds against the elderly. The committee sent questionnaires to over 1,300 respondents: 1,000 chiefs of police in both small rural and large metropolitan areas; all State consumer protection officers; and a nationwide sample of district attorneys and attorneys general. The purpose of the survey was: (1) To ascertain how serious is the problem of frauds against the elderly; (2) to determine which frauds are most frequently perpetrated against the elderly; and (3) to identify strategies that have been effective in combating these frauds.

## 1. CONS AND THEIR SCHEMES ARE WELL ORGANIZED, SOPHISTICATED, AND EFFECTIVE

Those who perpetrate frauds against the elderly, known as "cons," are well organized, sophisticated, and effective. Police authorities report that it is not uncommon for a con, upon leaving one successful location, to exchange the addresses of his easiest "marks" with another con who is just moving into the area. So well organized are some of these individuals that, in those instances where they wish to target the elderly, they have requested from State authorities lists of people who have qualified for a homestead homeowner's tax credit. This information is a valuable starting point because it both identifies older individuals and allows the targeting of those elderly who are homeowners. Older persons are targeted because of the age of their homes, the home's probable need of repair, and attractive equity levels of the homes.

Cons are extremely effective at defrauding the elderly. They know how to play upon the fears and hopes of their prey. To the poor, they make "get rich quick" offers; to the rich, they offer investment properties; to the sick and those with hopeless diseases, they offer "miracle cures" and "new scientific discoveries" for the relief of pain; to the healthy, they offer "fabulous vacation tours; and to those who are fearful of the future, they offer a confusing array of useless insurance plans.

To avoid being caught, cons usually avoid leaving a paper trail. Whenever possible they deal in cash. They avoid written estimates, avoid properly drawn contracts, and insist on haste to take advantage of a "today only" special price.

## 2. PERVASIVENESS OF FRAUD

The committee's survey has determined that fraud against the elderly is both widespread and pervasive. Law enforcement and consumer specialists from Maine to California and from Texas to North Dakota reported frauds against the elderly. No area of the country, whether rural, or large and metropolitan, was immune. Our respondents reported that not only was fraud widespread, but it pervaded nearly every aspect of the elderly's lives—from health care to housing, from investment programs to travel promotions.

## 3. FRAUD IS ON THE INCREASE

Consumer offices appear to be experiencing the greatest increase in complaints, with 72 percent of respondents reporting increases, while 68 percent of large city police departments and 51 percent of small city police departments reported increases. Respondents estimated that a surprising 84 percent of all complaints were said to be valid and not simply instances of misunderstanding. The reported increases in consumer complaints, combined with their assessed validity, gives credence to yet another study's finding: Fraud against people of all ages is increasing at the shocking rate of 12 percent per year. Testimony before the Special Committee on Aging by the U.S. Postal Inspection Service further confirms this increase, as do the findings of independent consumer groups, such as the Arthritis Foundation.

Once consumer offices were active within nearly every Federal agency. In recent years, many of these offices have become less adequately staffed and less adequately supported by their departments. A Federal program once operated by the Justice Department's Law Enforcement Assistance Administration, which made fraud prevention funds available to local communities, is no longer in effect. Similarly, other Federal funds earmarked for consumer service have been lost in block grants. This reduction in the Federal antifraud presence has had a marked impact upon the funding of State and local efforts to combat fraud.

Even though the fiscal data collected by the committee's survey reflected the period prior to the implementation of the 1982 budget cuts, 35 percent of State consumer offices were already experiencing budget cuts. The budgets of 47 percent of consumer offices remained the same during the 1981 fiscal year. Fifty-six percent of the heads of State consumer offices who reported 1981 budget changes stated that these changes reduced their ability to tabulate and resolve consumer complaints and conduct consumer education.

Police departments were not as affected by budget changes during the 1981 fiscal year. Twenty-one percent of large city chiefs of police and 27 percent of small city police departments experienced budget cuts in 1981.

The Alexandria, Va., Consumer Office (VCO) is an example of the effects of budget tightening. Even though in 1980 VCO won compensation of $107,357 in cash, goods, and services for city residences ($20,000 more than their budget for that year), in 1981, their staff was cut from six people to two, leaving the office without a director. The "Senior Consumer," a Florida publication mailed to 51,000 elderly once a month, and an associated toll-free consumer hotline are also being abolished because of budget restraints.

### 4. Elderly Persons are the Most Frequent Fraud Targets

A startling 77 percent of those responding to our survey said that the elderly are more often the targets of fraud than are younger people. While some would interpret this figure to mean that age indicates an individual's vulnerability to fraud, our research and that of others suggests this is not the case. The elderly are not victimized more often because, compared to other age groups, they are characteristically more attractive targets for fraud. The distinction is critical.

### 5. Fraud's Impact is Most Severe on the Elderly

While a person age 65 is not significantly different from a person age 64, the elderly as a group do have more difficulty coping with the impact of fraud than do younger people. So not only are the elderly more frequently targeted, but when victimized, they are less able to recover. Over 84 percent of all respondents said that this seems to hold true for the physical, emotional, and financial impact of frauds on the elderly.

## 6. TEN MOST HARMFUL FRAUDS AGAINST THE ELDERLY

Survey respondents were asked to identify the 10 most harmful frauds against the elderly. Harm was defined in terms of financial, emotional, and physical impact on elderly victims. The 10 most harmful reported frauds are:

(1) Quackery and medical-related frauds.
(2) Home repair and improvement fraud.
(3) Bunco schemes.
(4) Insurance fraud.
(5) Social frauds.
(6) Housing, land sales, and rental fraud.
(7) Business opportunity and investment fraud.
(8) Nursing home fraud.
(9) Automobile purchase and repair fraud.
(10) Funeral fraud.

## 7. HOW TO PREVENT FRAUD

The committee's survey and study have identified a number of ways to effectively combat frauds against the elderly. Perhaps the single most important is the realization by elderly persons, and those working with them, that an increased risk of victimization is not a necessary aspect of old age.

It appears that if the elderly were to become tougher consumers, that is, if they were to complain more and press their cases harder, they could effectively counter the self-fulfilling expectation that they are safe "marks." Sixty-seven percent of our survey respondents indicated that the elderly complain less than younger consumers.

If the research is correct, the elderly have a greater potential for reducing their susceptibility to fraud than any age group.

The committee identified 10 steps that elderly consumers can take to help lessen their vulnerability to fraud. These are:

(1) Check with officials (the police, consumer offices, the Better Business Bureau, State boards, and Federal agencies) before agreeing to any transaction.

(2) Learn about fraud and how to avoid it.

(3) Shop around before purchasing a service or product, getting references and comparing prices.

(4) Understand thoroughly any papers before they are signed. Check with a lawyer.

(5) Deal only with local, well-established, reputable officials.

(6) Never accept business from anyone who appears at your door without a specific request.

(7) Ask for the ID of any unknown solicitor before doing business with them (and have it verified).

(8) Never conduct business over the phone.

(9) Never pay for a service before it is performed to satisfaction.

(10) Never accept offers of quick profits.

If an older person is victimized by fraud, several steps should be taken as soon as possible:

(1) Notify officials immediately (the police, consumer offices, the Better Business Bureau, State boards, and Federal agencies).

(2) Allow the story to be told to prevent others from becoming victims of the same scheme.

(3) If the transaction is made by check, stop payment immediately after the fraud is discovered.

(4) Cooperate with prosecution of the crime and the crime's perpetrator.

(5) Save any evidence—such as receipts, the product itself, evidence of the faulty service or contracts.

The committee survey also found that there is currently little cooperation between law enforcement authorities and aging groups in their efforts to combat fraud. Fifty-six percent of respondents do not work with local or State aging organizations or area agencies on aging in any area of fraud prevention or resolution.

In summary, the survey and related study indicates that frauds against the elderly are increasing while resources to combat them are diminishing. Our research also has demonstrated that these fraud statistics are not necessary aspects of aging. There is a need for immediate and concentrated action by local, State, and Federal units of government, along with the aging network and the elderly themselves to reverse this trend.

## B. HEARING EXAMINES WAYS OF COMBATING FRAUDS AGAINST THE ELDERLY

In the spring of 1983, the committee held another in its series of consumer fraud hearings. This particular hearing, "Combating Frauds Against the Elderly," examined some of the strategies available to local, State, and Federal law enforcement and consumer protection agencies to address the documented increase in frauds involving elderly people. The hearing also provided evidence needed to support a renewed effort to secure passage of S. 450, "The Mail Order Consumer Protection Amendments of 1983" (see below).

Edna Willis, an 80-year-old resident of Concord, Pa., told the committee of how she and her husband were defrauded in a home improvement scheme. Typical of many older Americans who fall victim to these types of frauds, Mrs. Willis and her husband were tricked and later threatened into paying for substandard work. The director of a State consumer protection agency was joined by two State police officers who testified about methods of investigation and prosecution used against those who perpetrate these illegal acts.

Strong State consumer protection statutes, coupled with sophisticated criminal intelligence systems and creative prosecutorial efforts were discussed. All five Commissioners of the Federal Trade Commission and representatives of the U.S. Postal Inspection Service presented testimony concerning what was being done, as well as what more might be done to combat the frauds at the Federal level. Postal authorities estimated that 60 percent of all mail fraud schemes involve the elderly. A wide variety of consumer-related schemes affecting elderly people were addressed. Some of these included door-to-door and mail-order sales, insurance and investment frauds, automobile purchase and repair schemes, as well as problems associated with nursing homes, life care communities, and funeral frauds.

## C. PUBLIC LAW 98-186: MAIL ORDER CONSUMER PROTECTION AMENDMENTS OF 1983 BECOME LAW

In Mid-1981, Senators Pryor, Heinz, and Chiles introduced legislation, S. 1407, a bill to strengthen the enforcement powers of the U.S. Postal Service to combat mail fraud.

Testimony by Postal Inspection personnel indicated that mail frauds, estimated to involve billions of dollars per year, are on the increase. Postal authorities estimate that 60 percent of these frauds are perpetrated against older Americans. Due to low incomes, limited mobility, and poor health, many elderly rely on mail-order sales for conducting their business.

While the Postal Inspection Service has accumulated an impressive track record in putting an end to mail-fraud schemes, several obstacles impede its efforts to obtain an even greater number of successful prosecutions and to permanently ban those convicted of wrongdoing from reestablishing their fraudulent operations by simply changing their names or operations. This bill would do away with these impediments.

In order for the Postal Inspection Service to evaluate whether a product measures up to its advertised claims, the Service must send for the item through the mail in the same way an ordinary citizen does. It can take up to 3 months to receive a product, which must then be evaluated. The Service must then approach an administrative law judge or a U.S. attorney for action. The delay caused by this process is critical.

Defrauders of the elderly know about this procedure. As a result, they commonly place an ad, take orders for several months, then fill all the orders at one time as they close down their business operation, often simply to reopen under another name. By the time the inspectors receive their product, the perpetrators and their assets have vanished.

S. 1407 provided a solution to the problem. It would have given Postal Service employees the authority to appear in person at the address mentioned in a suspicious ad, present a postal money order for the amount of the purchase, and receive the product immediately.

In addition, the bill would have given the Chief Postal Inspector the authority to obtain an order barring named individuals from engaging further in the scheme which was the subject of a prior action. Violations of this order could be punished with civil penalties up to $10,000 for each violation.

S. 1407 would not have added significant new costs to the Treasury. It would have, if passed, gone a long way toward providing the Postal Inspection Service with the necessary tools to move promptly and efficiently against those who victimize elderly persons.

S. 1407 was favorably reported by the Senate Committee on Governmental Affairs on April 29, 1982. The full Senate voted by unanimous consent to adopt S. 1407 on May 19, 1982. The House companion to this measure, H.R. 7044, was reported by the Post Office and Civil Service Committee on October 4, 1982. On December 13, 1982, the House passed H.R. 7044 with amendments. However, the measure was not considered by the Senate again during the 97th Congress.

On February 3, 1983, Aging Committee Chairman Heinz, Ranking Minority Member Glenn, and Senator Stevens of the Committee on Govenmental Affairs joined Senator Pryor in introducing S. 450. S. 450 is substantially similar to S. 1407, as introduced in the previous Congress. On February 8, 1983, Members of the House introduced H.R. 1342, a measure similar to S. 450. Against a backdrop of an additional Senate Aging Committee hearing, which documented continued widespread problems with mail fraud and the elderly, both bodies acted to pass their respective measures. On November 30, 1983, the President signed Public Law 98-186, the "Mail Order Consumer Protection Amendment of 1983" into law. The measure strengthens the ability of postal authorities to combat improper and fraudulent use of the mails.

# SUPPLEMENTAL MATERIAL

---

## Supplement 1

## 1983 HEARINGS HELD BEFORE THE SENATE SPECIAL COMMITTEE ON AGING

### QUALITY ASSURANCE UNDER PROSPECTIVE REIMBURSEMENT PROGRAMS, WASHINGTON, D.C., FEBRUARY 4, 1983, HON. JOHN HEINZ, CHAIRMAN, PRESIDING

#### WITNESSES

David Marks, former assistant district attorney, Galveston, Tex.

Michael Zimmerman, Associate Director, Human Resources Division, U.S. General Accounting Office, Washington, D.C.; accompanied by James Barnett, Dallas, Tex., Regional office, GAO; and Robert Eiffert, Health Care Financing Adviser, GAO, Washington, D.C.

Marc B. Allen, executive director, Essex Physicians Review Organization, Inc., South Orange, N.J.; and Dennis J. Duffy, executive director, Suburban Medical Review Association, Inc., Kenilworth, N.J.

Carolyne K. Davis, Ph. D., Administrator, Health Care Financing Administration, U.S. Department of Health and Human Services, Washington, D.C.; accompanied by Daniel Bourque, Deputy Administrator; Martin Kappert, Deputy Associate Administrator for Operations; and Patrice Feinstein, Associate Administrator for Policy.

Robert Gay, president, Autumn Hills Convalescent Centers, Inc., Houston, Tex.; accompanied by Roy Minton, Esq., Maddie Lock, and Ron Pullmeyer.

#### ISSUES RAISED AND TESTIMONY SUMMARY

As a result of the administration's proposal to implement a national prospective payment system for hospital reimbursement under medicare, Chairman John Heinz called this hearing to examine the role of mechanisms which assure that patients receive a certain minimum level or adequate quality of care. Over the past 15 years, the Aging Committee has uncovered extensive and dramatic examples of the problems inherent in the cost-based retrospective payment system of health insurance. Examples of fraud, waste, and abuse, estimated to total $10 billion annually in both medicare and medicaid were documented last year. The fraud, waste, and quality of care of the present reimbursement system have proved resistant to all efforts to eliminate them signifies its failure.

Recognizing the fact that a more basic reform was necessary, the committee had long called for the development of a prospective payment system associated with more cost-conscious financial incentives on the part of providers. Since a prospective payment system is in essence a contract in which the Government agrees to pay a specific amount for a specified service, it becomes the Government's responsibility to insure that the essential services are dilivered. The purpose of this hearing was to assess the Government's ability to meet this important responsibility.

The committee heard testimony from witnesses with hands-on experience in prospective reimbursement systems at the State level and reviewed the quality assessment mechanisms developed by the prosecutors, the State medicaid fraud investigators, and Rice University experts in connection with the Autumn Hills Convalescent Center in Galveston, Tex., to which 38 indictments of murder had been issued by a grand jury.

### COMBATING FRAUDS AGAINST THE ELDERLY, WASHINGTON, D.C., MARCH 1, 1983, HON. JOHN HEINZ, CHAIRMAN, PRESIDING

#### WITNESSES

James C. Miller III, Chairman, Federal Trade Commission, Washington, D.C.; accompanied by David A. Clanton, Commissioner; Michael Pertschuk, Commissioner; Patricia P. Bailey, Commissioner; and George W. Douglas, Commissioner, Federal Trade Commission, Washington, D.C.

Charles P. Nelson, Assistant Chief Postal Inspector, U.S. Postal Service, Washington, D.C.; accompanied by George C. Davis, Assistant General Counsel; and Wayne Kidd, Manager, Fraud Branch, Washington, D.C.

Edna Willis, Concord, Pa.; accompanied by Elaine Biddle, daughter of Mrs. Willis; and Trooper Malcolm Murphy, Pennsylvania State Police, Philadelphia, Pa.

Clair E. Villano, president, National Association of Consumer Protection, Wisconsin Department of Justice, Madison, Wis.

Stephen J. Nicks, director, Office of Consumer Protection, Wisconsin Department of Justice, Madison, Wis.

Terry Getsay, criminal intelligence analyst, Illinois Department of Law Enforcement, Springfield, Ill.

#### ISSUES RAISED AND TESTIMONY SUMMARY

As a result of a 1981 field hearing held in Harrisburg, Pa., to review the local impact of consumer frauds on the elderly, it was revealed that such frauds were indeed a significant problem with potentially enormous implications for the elderly. This hearing was held to release findings of a national survey of over 1,300 police chiefs, district attorneys, and consumer protection offices conducted by the committee. The purpose of the questionnaire was to assess the nature and frequency of consumer and economic frauds, the impact of these frauds on the elderly, and the resources available to combat these abuses.

The report released detailed these findings and concluded the following five points: (1) Consumer frauds are widespread and pervasive; (2) consumer and economic frauds are increasing; (3) the elderly are considered a prime target for these abuses; (4) those who perpetrate these crimes are well organized, sophisticated, and effective; and (5) despite the increase in the level of fraud, resources available to combat this problem are diminishing.

Also found in this survey were the 10 most harmful frauds to the elderly—quackery, and medical-related bunco schemes, insurance social cons which feed on a victim's compassion and loneliness, housing, land sale and rental, business and investment schemes, nursing home, automobile purchase and repair, and deceptive funeral sales practices.

Witnesses spoke to these problems and the present solutions. Members of the committee heard how the elderly are defrauded, and saw the impact of these abuses on one of its victims. Testimony was also given by representatives of State, local, and Federal agencies charged with preventing and controlling these abuses.

## Energy and the Aged: The Impact of Natural Gas Deregulation, Washington, D.C., March 17, 1983, Hon, John Heinz, Chairman, Presiding

### WITNESSES

Hon. Donald P. Hodel, Secretary, U.S. Department of Energy, Washington, D.C.

Susan M. Shanaman, chairman, Pennsylvania Public Utility Commission, Harrisburg, Pa.

George H. Lawrence, president, American Gas Association, Arlington, Va.

Edwin Rothschild, assistant director, Citizen Labor Energy Coalition, Washington, D.C.

Vita Ostrander, president-elect, American Association of Retired Persons, Washington, D.C.

Joseph Rourke, assistant to the President, National Council of Senior Citizens; accompanied by Eric Shulman, legislative director, Washington, D.C.

### ISSUES RAISED AND TESTIMONY SUMMARY

The purpose of this hearing was to examine the potential impact on elderly consumers of the administration's proposals to decontrol natural gas. Energy costs faced by older Americans, especially those at the poverty level, are alarming. Older people pay far more for energy as a percentage of their income than any other group—nearly 30 percent of their average incomes compared to 8 percent for the average household. Those who are living on fixed incomes cannot make the substantial financial rearrangements necessary to pay for escalating energy costs or for retrofitting to make their homes more energy efficient. As Congress addressed the possibility of decontrolling natural gas as well as other energy policies, members of the committee felt that it must also be mindful of its continuing obligations to those who cannot readily adapt to price changes.

Three specific issues were addressed by witnesses. First, the impact of current price increases in natural gas to residential consumers, along with the problems that elderly consumers are having in paying their utility bill, and the extent to which the elderly are threatened by utility cutoffs was examined. Second, they reviewed the effects of anticipated price changes in natural gas under the administration's proposal on the elderly consumer, and the appropriateness of consumer safeguards included in the administration's proposal. And finally, witnesses explored the adequacy of existing Federal resources that would be needed in the future to offset projected increases in energy costs themselves, and the Government's ability to continue to assist low income and elderly.

## SOCIAL SECURITY REVIEWS OF THE MENTALLY DISABLED, WASHINGTON, D.C., APRIL 7 AND 8, 1983, HON. JOHN HEINZ, CHAIRMAN, PRESIDING

### WITNESSES

### *April 7, 1983*

Peter J. McGough, Associate Director, Human Resources Division, U.S. General Accouting Office, Washington, D.C.; accompanied by Robert Wychulis, Assignment Manager, and Beryce MacLennan, Ph. D., Clinical Psychologist.

Beatrice S. Braun, M.D., director, preventive treatment unit, St. Vincent's Hospital and Medical Center, Westchester Branch, Harrison, N.Y.

Lois Jahsmann, executive director, Hedwig House, Inc., Norristown, Pa.; accompanied by Arthur Clyde, coordinator, Hedwig House, Pottstown, Pa.; and social security beneficiaries Merritt F. Reish and James Stiteler.

Janet A. Conser, director, Senior Citizens Law Project, Wilkes-Barre, Pa.

Hon. Stephen H. Sachs, attorney general, State of Maryland, Baltimore, Md.

Louis O. Treadway, commissioner, Orange County, Fla., representing the National Association of Counties, Washington, D.C.

Hon. Cesar A. Perales, commissioner, New York State Department of Social Services, Albany, N.Y.

Hon. Carol Bellamy, city council president, New York, N.Y.

Arthur T. Meyerson, M.D., vice chairman and clinical director, Mt. Sinai School of Medicine/Hospital, New York, N.Y., representing the Amrerican Psychiatric Association, Washington, D.C.

### *April 8, 1983*

Paul B. Simmons, Deputy Commissioner for Programs and Policies, Social Security Administration, U.S. Department of Health and Human Services; accompanied by Louis B. Hays, Associate Commissioner for Hearings and Appeals; Patricia M. Owens, Director, Office of Disability Programs; and Donald A. Gonya, Assistant General Counsel, Social Security Division, Office of General Counsel.

### ISSUES RAISED AND TESTIMONY SUMMARY

This 2-day hearing focused on the treatment of mentally disabled persons under the Federal programs designed to assist them. Over the past 2 years, nearly half of those social security and supplemental security disability beneficiaries selected for continuing disability reviews were told by the Social Security Administration that they no longer met the definition of disability and, therefore, had their benefits stopped. These continuing disability reviews drew the attention of the Aging Committee because nearly 60 percent of all disabled workers are over the age of 55, and nearly 75 percent are over age 50. In addition, the committee was presented with repeated illustrations of specific cases where the reviews were clearly conducted in an inadequate manner.

As chairman of the committee, Senator Heinz convened this hearing to address the concerns shared by other members of the committee regarding the quality of the reviews performed on individuals suffering from severe mental disabilities. Members heard officials from the U.S. General Accounting Office, who released results of a GAO investigation requested by Senator Heinz, on the administration of the review program. They also heard about the human toll of these reviews through the words of beneficiaries and individuals who work on a daily basis with the mentally ill; from State, county, and city governments about the impact of the Federal policies on their communities; and from a medical expert on the scientific validity of the criteria which social security uses to judge the severity of a mental disability. On day two of the hearing, the Social Security Administration provided its perspective on the reviews of the mentally disabled, and responded to charges made to the administration.

## THE FUTURE OF MEDICARE, WASHINGTON, D.C., APRIL 13, 1983, HON. JOHN HEINZ, CHAIRMAN, PRESIDING

### WITNESSES

Alice M. Rivlin, Ph. D., Director, Congressional Budget Office, Washington, D.C.; accompanied by Paul B. Ginsberg, Deputy Assistant Director, Human Resources and Community Development Division; and Marilyn Moon, Analyst, Human Resources and Community Development Division.

Carolyne K. Davis, Ph. D., Administrator, Health Care Financing Administration, U.S. Department of Health and Human Services, Washington, D.C.; accompanied by Dr. George Schieber, Director, Office of Policy Analysis; and Patricia Feinstein, Associate Administrator for Policy.

Joseph P. Newhouse, Ph. D., director, economics department, the Rand Corp., Santa Monica, Calif.

Gail R. Wilensky, Ph. D., senior research manager, National Center for Health Services Research, Rockville, Md.

Karen Davis, Ph. D., chairman, department of health policy and management, School of Hygiene and Public Health, Johns Hopkins University, Baltimore, Md.

### ISSUES RAISED AND TESTIMONY SUMMARY

The first in a series of hearings held by the Aging Committee on the future of medicare focused on the long-term financial picture for the medical hospital insurance trust fund. Because the cumulative projected deficit of medicare is so large, maintaining the solvency of the health insurance trust fund will require major reform in both medicare and the Nation's health care system as well. Witnesses appearing before the committee discussed the potential options for maintaining medicare's solvency and the impact of these options on beneficiaries.

In preparation for this hearing, Senator John Heinz requested from the Congressional Budget Office an analysis of projections for the HI trust and options sufficient to meet future deficits. The CBO paper, released by the Aging Committee during these proceedings, showed that medical care costs, particularly hospital, were growing faster than the taxes on payroll which support it. Therefore, it was determined that any longrun solution must contain measures to control the rapid inflation of medical costs. As one of the first and most comprehensive analysis of medicare's financial future, this CBO paper, helped focus attention on the problems faced in the solvency of the medicare system.

## LIFE CARE COMMUNITIES: PROMISES AND PROBLEMS, WASHINGTON, D.C., MAY 25, 1983, HON. JOHN HEINZ, CHAIRMAN, PRESIDING

### WITNESSES

Doris R. Schwartz, resident, Foulkeways Life Care Community, Gwynedd, Pa.

Robert M. Ball, visiting scholar, Center for the Study of Social Policy, Washington, D.C.

Howard E. Winklevoss, Ph. D., actuary, Winklevoss & Associates, Philadelphia, Pa.

David L. Cohen, attorney, Ballard, Spahr, Andrews & Ingersoll, Philadelphia, Pa.

Lloyd W. Lewis, executive director, Kendal-Crosslands, Kennett Square, Pa.

Hon. Thomas M. Jenkins, superior court judge, State of California, Redwood, Calif.

Helen Bishop, Mobile, Ala.; accompanied by her son Sgt. Jack Bishop, Mobile, Ala., Police Department.

Patricia P. Bailey, Commissioner, U.S. Federal Trade Commission, Washington, D.C.; accompanied by Henry Whitlock, Staff Attorney, Federal Trade Commission, regional office, New York, N.Y.

### ISSUES RAISED AND TESTIMONY SUMMARY

"Life Care Communities: Promises and Problems," marked the first time a congressional committee turned its attention to this fast-growing and increasingly important housing and health care alternative for older Americans. Chairman Heinz and other members of the Aging Committee expressed concern that the credibility of life care, which appears to be an attractive option for millions of older Americans, may be damaged by inept and fraudulent action by a few. They were also concerned that only 11 of the Nation's 50 States have laws governing the operation of life care facilities, and that these have often proved inadequate.

Testimony by witnesses examined both the promise of life care and the problems that are associated with it, as the development of the concept of life care communities stands at a critical point.

### DRUG USE AND MISUSE: A GROWING CONCERN FOR OLDER AMERICANS (JOINT HEARING WITH THE HOUSE SELECT COMMITTEE ON AGING, SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE), WASHINGTON, D.C., JUNE 28, 1983, HON. JOHN HEINZ AND HON. CLAUDE PEPPER, COPRESIDING

#### WITNESSES

Michael T. Flaherty, director, Addiction Treatment Center, St. Francis General Hospital, Pittsburgh, Pa.

Nettie Apple Powell, Pittsburgh, Pa.

James N. Hall, director, Up Front, Inc., Coconut Grove, Fla.

Rose Zimmy, Everett, Mass.; accompained by her daughter, Gloria Zimmy.

Jonathan D. Lieff, M.D., director of psychiatry and chief of geriatrics, Lemuel Shattuck Hospital, Jamaica Plains, Mass.

Peter P. Lamy, Ph. D., director, Center for the Study of Pharmacy and Therapeutics for the Elderly, School of Pharmacy, University of Maryland, Baltimore, Md.

Jerome L. Avorn, M.D., assistant professor of social medicine and health policy, Division on Aging, Harvard University Medical School, Boston, Mass.

Jack Christy, legislative representative, American Association of Retired Persons, Washington, D.C.; accompained by Nancy Olins, AARP pharmacy service.

F. Gilbert McMahon, M.D., director, Clinical Research Center, Tulane University, New Orleans, La.

Mark Novitch, M.D., Deputy Commissioner, Food and Drug Administration, U.S. Department of Health and Human Services, Washington, D.C.; accompained by Dr. Robert Temple, Acting Director, Office of New Drug Evaluation; and Dr. Lloyd G. Millstein, Acting Director, Division of Drug Advertising and Labeling.

#### ISSUES RAISED AND TESTIMONY SUMMARY

Cochaired by Senator John Heinz and Congressman Claude Pepper, this hearing focused on the subject of drug use and misuse among our Nation's elderly. Many older Americans suffer needlessly because of drug misuse—a pervasive and potentially deadly problem. Doctors, pharmacists, the drug industry, and the U.S. Food and Drug Administration must pay careful attention to the special problems caused by the interaction of physiological change and drug usage. Because these problems are rooted primarily in an absence of relevant and useful information, this hearing was held to hear from witnesses who develop, sell, prescribe, and use medication in order to stimulate interest and action among older Americans to learn more about the drugs they take.

In addition to the hearing, the Senate Aging Committee released a print entitled, "You and Your Medicines: Guidelines for Older Americans," designed to explain and advise older Americans as to the proper use of medicines.

## COMMUNITY ALTERNATIVES TO INSTITUTIONAL CARE, HARRISBURG, PA., JULY 6, 1983, HON. JOHN HEINZ, CHAIRMAN, PRESIDING

### WITNESSES

Hon. Walter W. Cohen, secretary, Department of Public Welfare, State of Pennsylvania, Harrisburg, Pa.; accompanied by Jennifer Howse, deputy secretary for mental retardation; and Gerald Radke, deputy secretary for medical assistance.

John Swain, Philadelphia, Pa.

David M. Eisenberg, Ph. D., director, Channeling Demonstration Project, Philadelphia, Pa.

Richard Browdie, Philadelphia, Pa., representing the Pennsylvania Association of Area Agency on Aging Directors.

Dolores Rodrigues, Pittsburgh, Pa.

N. Karen Kelly, president, Pennsylvania Association for Retarded Citizens, Pittsburgh, Pa.

Polly Spare, president, Pennsylvania League of Concerned Families of Retarded Citizens, Inc., Doylestown, Pa.

### ISSUES RAISED AND TESTIMONY SUMMARY

In Harrisburg, Pa., Chairman John Heinz heard testimony from witnesses which focused on steps being taken in Pennsylvania to place the elderly and the developmentally disabled in the community in an effort to learn more about what types of alternatives to institutional care can be implemented on a broader, perhaps national, scale. Senator Heinz called for a more coherent national policy that would stress a continuum of service choices. Although many efforts have been made to improve current policies, they are fragmented, emphasize institutional care, and erect roadblocks to further community placement of elderly and developmentally disabled persons. The critical ingredients missing remain the resources and the unifying structure to manage individual cases properly. To prevent human warehousing, stress the maximization of self-care, and allow all citizens to lead normal lives in the least restrictive setting, a coherent Federal policy on the future direction of deinstitutionalization is needed. Testimony was geared toward sorting out the issues, problems, and challenges in developing a national policy of deinstitutionalization.

## CRIME AGAINST THE ELDERLY, LOS ANGELES, CALIF., JULY 6, 1983, HON. PETE WILSON, PRESIDING

### WITNESSES

G. Albert Howenstein, Jr., executive director, Office of Criminal Justice Planning, State of California, Sacramento, Calif.

Mia Baker, administrative coordinator, city of Los Angeles Attorney's Victim-Witness Assistance Program, Los Angeles, Calif.
Deane Dana, supervisor, Los Angeles County, Calif.
Darrell Girton, Los Angeles, Calif.
Rosa Linares, Los Angeles, Calif.
Frank Ivey, Los Angeles, Calif.
Greg Rigah, sheriff, Sheriff's Headquarters Crime Prevention Unit, Los Angeles, County Calif.; accompanied by Lt. Robert Fleming, head, forgery unit.
Melvin D. Moore, Assistant Inspector in Charge, Los Angeles, California Division, U.S. Postal Inspection Service, Los Angeles, Calif.
Ira Handleman, coordinator, Beverly-Fairfax Community Patrol, Los Angeles, Calif.
Terry Warsaw, Beverly-Fairfax Community Patrol, Los Angeles, Calif.
Marlene Singer, director, home secure program on crime and the elderly citizen, Jewish Family Services of Los Angeles, Los Angeles, Calif.
Ruth White, Rampart neighborhood watch program, Los Angeles, Calif.
Capt. F. E. Piersol, commanding officer, Rampart area, Los Angeles Police Department, Los Angeles, Calif.
Leonard J. Hansen, chairman, editor, and publisher, Senior World Publications, Inc., El Cajo, Calif.

### ISSUES RAISED AND TESTIMONY SUMMARY

Senator Pete Wilson called this special field hearing on the problems of crime and the aging. One of the cruelist problems afflicting the elderly in the Nation is that of fear, induced by crime—both crime threatened and actually practiced. Testimony by witnesses focused on aid to the victims of crime, the prevention of fraud, and the prevention of crime through measures that can be taken by individuals to both assist themselves and the local law enforcement officials.

Senator Wilson heard from experts in criminal justice and crime prevention, government officials, and victims of crime whose problems have too often been neglected by efforts directed instead at the protection of criminals.

## HOME FIRE DEATHS: A PREVENTABLE TRAGEDY, WASHINGTON, D.C., JULY 28, 1983, HON. JOHN HEINZ, CHAIRMAN, PRESIDING

### WITNESSES

John C. Gerard, representative, National Fire Protection Association, Washington, D.C.
Andrew McGuire, executive director, the Burn Council, San Francisco General Hospital, San Francisco, Calif.
Nancy Harvey Steorts, Chairman, U.S. Consumer Product Safety Commission, Washington, D.C.; accompanied by Betsy Wilansky, representing Stuart M. Stateler, Commissioner, U.S. Consumer Product Safety Commission.

Edward Press, M.D., M.P.H., representing the American Association of Public Health Physicians, Portland, Oreg.

John P. Rupp, Washington, D.C., representing the Tobacco Institute.

Matthew J. Farrell, assistant chief and Manhattan Borough commander, New York City Fire Department, New York, N.Y.; accompanied by Robert J. Butler, deputy assistant chief.

James E. Jones, Jr., Government affairs representative, Alliance of American Insurers, Washington, D.C.

Peter Dys, executive director, Lancaster County Office of Aging, Lancaster, Pa.

### ISSUES RAISED AND TESTIMONY SUMMARY

Each year at least 6,000 people die in residential fires. Since a majority of these deaths are preventable, the Aging Committee at the request of Chairman John Heinz, called this hearing to focus on two measures that can substantially reduce the risk of home fire deaths. These are (1) the development of a firesafe cigarette, and (2) the installation of smoke detectors in homes.

Witnesses gave testimony on the feasibility of the firesafe cigarette—one that extinguishes before igniting mattresses or bedding materials, and most common upholstery. Members of the Aging Committee also heard from experts on smoke detectors as inexpensive and highly effective home fire prevention measures.

The purpose of this hearing was to explore what the Federal Government could do to reduce the tragedy of thousands of lives needlessly lost in home fires. As a result of these proceedings, the chairman introduced legislation calling for a Federal study on the feasibility of a firesafe cigarette and directed the Aging Committee staff to develop proposals to establish Federal programs for the distribution and installation of smoke detectors for those elderly and needy citizens.

## ENDLESS NIGHT, ENDLESS MOURNING: LIVING WITH ALZHEIMER'S, NEW YORK, N.Y., SEPTEMBER 12, 1983, HON. JOHN HEINZ, CHAIRMAN, PRESIDING

### WITNESSES

Dorothy Kirsten French, Los Angeles, Calif.

Peggy Morscheck, coordinator, Philadelphia Chapter, Alzheimer's Disease and Related Disorders, Ardmore, Pa.

Peter J. Strauss, Esq., New York, N.Y.

Ethel L. Mitty, R.N., director of nursing, Jewish Home and Hospital for Aged, New York, N.Y.

Leslie S. Libow, M.D., chief of medical services, Jewish Home and Hospital for Aged, New York, N.Y.

Janet S. Sainer, commissioner, New York City Department for the Aging, New York, N.Y.

Robert N. Butler, M.D., Brookdale professor of geriatrics and adult development, Mt. Sinai Medical Center, New York, N.Y.

Samuel Sadin, director, Institute on Law and Rights of Older Adults, Brookdale Center on Aging, Hunter College, New York, N.Y.

### ISSUES RAISED AND TESTIMONY

Senators John Heinz and Larry Pressler took the Aging Committee to a New York City nursing home for the elderly to hear testimony on one of the most frightening illnesses to strike the elderly—Alzheimer's disease. A form of senile dementia, for which no cause or cure is known, Alzheimer's disease and related research activities have been the subject of many congressional hearings. This particular hearing focused on the issue of care by hearing from family members and professional caregivers about what is being done and what more can be done for the caregivers, as well as for the patients. The Senators also had the opportunity to hear from active leaders of New York City who have done much to improve the lives of older Americans, as they prepared for a major conference on Alzheimer's disease.

This hearing was designed as a factfinding tool to aid in putting together a package of bills[1] which would help provide additional long-term care services to make it easier to care for older family members, like those with Alzheimer's, in the home.

## CONTROLLING HEALTH CARE COSTS: STATE, LOCAL, AND PRIVATE SECTOR INITIATIVES, WASHINGTON, D.C., OCTOBER 26, 1983, HON. JOHN HEINZ, CHAIRMAN, PRESIDING

### WITNESSES

Humphery Taylor, president, Louis Harris & Associates, Inc., New York, N.Y.

Carl J. Schramm, Ph. D., J.D., director, Center for Hospital Finance and Management, Johns Hopkins University, Baltimore, Md.

James Morone, Ph. D., assistant professor of political science, Brown University, Providence, R.I.

John D. Crosier, executive director, Massachusetts Business Roundtable, Inc., Waltham, Mass.

Frank A. Sloan, Ph. D., executive director, Health Policy Center, Vanderbilt University, Nashville, Tenn.

Lynn Etheridge, scholar-in-residence, Center for Health Policy Studies, Georgetown University, Washington, D.C.

Leona Butler, director, contracting and public affairs, Blue Cross of California, Oakland, Calif.

Jack Cooke, consultant, Health Systems Research, Inc., Boston, Mass.

Leonard Schaeffer, president, Group Health, Inc., Minneapolis, Minn.

### ISSUES RAISED AND TESTIMONY SUMMARY

This hearing was a continuation in the series of hearings by the Aging Committee on the future of medicare. In particular, the witnesses focused on the excessive growth rates of health care costs, not limited to medicare alone. They addressed how State, local, and private sector initiatives can make the delivery of health care more cost effective in the face of possible bankruptcy by medicare. These initiatives include State systems which set hospital rates, not just for public health programs, but for all payers, which may be applied in a national system.

---

[1] The Home Health Tax Credit Act, the Health Care Coordination Act, and the Independent Community Care Act.

The Aging Committee released a print outlining these health cost-containment programs, State by State, at this hearing.

Witnesses also spoke on quality of care actually received by the patient in these systems and helped assess the impact of locally based efforts at organizing and managing delivery of health care as a means of curtailing costs.

Members hoped to find solutions to the approaching cost crisis in medicare and in the entire health care system.

## SOCIAL SECURITY: HOW WELL IS IT SERVING THE PUBLIC? WASHINGTON, D.C., NOVEMBER 29, 1983, HON. JOHN HEINZ, CHAIRMAN, PRESIDING

### WITNESSES

Hon. Martha McSteen, Acting Commissioner of Social Security, U.S. Department of Health and Human Services, Washington, D.C.

Carole Williams, Pittsburgh, Pa.

Agnes Ballock, Hawk Run, Pa.

James Badgero, Worthington, Ohio.

Paul Welch, Esq., staff attorney, Central Pennsylvania Legal Services, New Bloomfield, Pa.

James Nieberline, Glen Burnie, Md.

Joseph Delfico, Associate Director, Human Resources Division, U.S. General Accounting Office, Washington, D.C.

John Harris, Claims Representative, Social Security Administration, past president, National Council of Social Security Field Operations Locals, American Federation of Government Employees (AFGE), St. Paul, Minn.; accompanied by Chris Sigler, president, AFGE Social Security State Local No. 3448, Bowling Green, Ohio; Thomas Wacter, regional vice president, AFGE Social Security Local No. 220, Philadelphia, Pa.; Kris Kramer, president, AFGE Social Security Local No. 3231, Ambridge, Pa.; and Barbara Lawson, Chula Vista, Calif.

Herbert R. Doggette, Deputy Commissioner for Operations, Social Security Administration, Washington, D.C.

Louis D. Enoff, Acting Deputy Commissioner for Programs and Policy, Social Security Administration, Washington, D.C.

### ISSUES RAISED AND TESTIMONY SUMMARY

Chairman John Heinz called this hearing to review the results of a U.S. General Accounting Office study on the question of the fundamental assurance that social security recipients receive their correct benefits at the proper time. This study, requested by the Aging Committee, found that on the basis of 208 sample cases, one in five retirees receives an incorrect payment due to an administrative error at some time over a 5-year period. Even more disturbing is the finding that the error is usually in the favor of the Social Security Administration, and usually goes undetected.

Appearing before the committee were four people who had experienced problems with the social security system. Their stories helped to give an understanding of the kinds of problems individuals encounter when attempting to correct errors and to illustrate the persistence and ingenuity needed to detect such errors and prompt Social Security to correct them. Other witnesses helped to illustrate the extent to which changes in the administration of social security have made the daily work of this agency more difficult and error prone.

## THE CRISIS IN MEDICARE: PROPOSALS FOR REFORM, SIOUX CITY, IOWA, DECEMBER 13, 1983, HON. CHARLES GRASSLEY, PRESIDING

### WITNESSES

Gene Hyde, Administrator, region VII, Health Care Financing Administration, Kansas City, Mo.

Gary Levitz, assistant to the director, University of Iowa Hospitals and Clinics, Iowa City, Iowa.

Frank Severino, Health Policy Corp., Des Moines, Iowa.

Dr. R. Melvin Henderson, vice president of academic affairs, Simpson College, Indianaola, Iowa.

Dr. Robert Pfaff, president, Iowa Foundation for Medical Care, West Des Moines, Iowa.

Don Rowan, executive vice president, Iowa Federation of Labor, Des Moines, Iowa.

Daryl Siebens, Iowa Farm Bureau Federation, Akron, Iowa.

Harold Linden, vice president and director of Government relations, Blue Cross of Western Iowa and South Dakota, Sioux City, Iowa.

Paul Aardsma, public relations director, Iowa Commission on Aging, Des Moines, Iowa.

Sister Elizabeth Mary Burns, president, Marian Health Center, Sioux City, Iowa.

Dr. Chuck Seagrave, Congressional Budget Office, Washington, D.C.

### ISSUES RAISED AND TESTIMONY SUMMARY

The purpose of the hearing was to gather comments on the coming crisis in medicare and examine various options for reforming the program with a particular emphasis on the part A hospital insurance provisions. Witnesses were asked their perception of the problems confronting medicare, the pros and cons of various reform proposals, and to evaluate the new prospective payment system for hospitals, with a careful regard for the delicate balance between the various health care users and providers who together make up our health care system.

The committee heard testimony on the magnitude of the problems facing the medicare trust fund, and the projections as to when the fund would face insolvency. HCFA presented the administration's most recent budget proposals, and its view on broader reform possibilities. CBO outlined three major options for dealing with the problem which served as a basis for discussion on the various alternatives. Those options included changes in the reimbursement to providers, benefit restructuring, and higher taxes.

Differences of opinion were noted in the amount of additional burden each major sector should bear in any reform package. All expressed concern with the need to maintain easily accessible, high quality health care. The importance of utilization review was a topic of shared concern, particularly with the implementation of the new prospective payment system for hospitals. Several individuals expressed reservations with this new system, and cautioned Congress to keep a watchful eye on its development.

## Supplement 2

## COMMITTEE PRINTS AND REPORTS PRINTED BY THE SPECIAL COMMITTEE ON AGING IN 1983

1. DEVELOPMENTS IN AGING: 1982: VOLUME 1, FEBRUARY 1983.
2. DEVELOPMENTS IN AGING: 1982: VOLUME 2, FEBRUARY 1983.
3. CONSUMER FRAUDS AND ELDERLY PERSONS: A GROWING PROBLEM, FEBRUARY 1983.
4. ACTION ON AGING LEGISLATION IN THE 97TH CONGRESS, MARCH 1983.
5. PROSPECTS FOR MEDICARE'S HOSPITAL INSURANCE TRUST FUND, MARCH 1983.
6. THE PROPOSED FISCAL YEAR 1984 BUDGET: WHAT IT MEANS FOR OLDER AMERICANS, MARCH 1983.
7. PUBLICATIONS LIST, APRIL 1983.
8. YOU AND YOUR MEDICINES: GUIDELINES FOR OLDER AMERICANS, JUNE 1983.
9. HEAT STRESS AND OLDER AMERICANS: PROBLEMS AND SOLUTIONS, JULY 1983.
10. CURRENT DEVELOPMENTS IN PROSPECTIVE REIMBURSEMENT SYSTEMS FOR FINANCING HOSPITAL CARE, OCTOBER 1983.
11. PROTECTING OLDER AMERICANS AGAINST OVERPAYMENT OF INCOME TAXES, DECEMBER 1983.

Supplement 3

# STAFF OF THE SENATE SPECIAL COMMITTEE ON AGING

## MAJORITY STAFF

Phone: (202) 224-5364

John C. Rother -- *Staff Director and Chief Counsel*

Robin L. Kropf -- *Chief Clerk*

Isabelle Claxton -- *Communications Director*

### INVESTIGATIONS

David Holton
Ruth Ann Weidel
Terri Kay Parker
David Schulke

Medicare and Medicaid Fraud and Abuse, Boarding Home and Nursing Home Issues, Consumer Protection

### INCOME SECURITY

Larry Atkins
Anthony Knettel
Paul Steitz
Linda Josephson

Economic Security Issues, Retirement Income, Pensions, Social Security, Disability, Railroad Retirement

### HOUSING AND SERVICES

Michael Rodgers
Stephen Somers
Ann Gillespie

Services (Older Americans Act, Education, Transportation, Rural Elderly), Crime, Energy, Employment, Age Discrimination, Federal Budget, Housing

### HEALTH

Frank Kinney
Barbara Krimgold
Tricia Neuman

Health, Medicare and Medicaid, Long-Term Care, Women's Issues

Claire Smrekar -- *Legislative Correspondent*
Margaretta Engle -- *Senior Aide*
James Mattison -- *Senior Aide*
Paula Dietz -- *Staff Assistant*
Kate Latta -- *Staff Assistant*
Leslie Malone -- *Staff Assistant*
Cindy DeAngelus -- *Staff Assistant*
Gene Cummings -- *Printing Assistant*
Elizabeth Vierck -- Analyst

## MINORITY STAFF

Phone: (202) 224-1467

Diane Lifsey, *Staff Director*

Jane Jeter, *Professional Staff Member*

Eileen P. Bradner, *Professional Staff Member*

Roberta Lipsman, *Professional Staff Member*

Christopher C. Jennings, *Legislative Correspondent*

Tammy Lipscomb, *Staff Assistant*

Lisa Landwirth, *Staff Assistant*

## Supplement 4

# PUBLICATIONS LIST

## HOW TO ORDER COPIES OF COMMITTEE HEARINGS AND REPORTS

Copies of committee hearings and reports are available from the committee and from the Government Printing Office. The date of publication and the number of copies you would like generally determine which office you should contact in requesting a publication.

The following are guidelines for ordering copies of committee publications:

—Single copies of publications printed after January 1981 can be obtained from the committee.

—Any publication printed before January 1981 should be ordered from the Government Printing Office.

—If you would like more than one copy of a publication, they should be ordered from the Government Printing Office.

These guidelines are altered under the following circumstances:

*If the committee supply has been exhausted—as indicated by one asterisk—contact the Government Printing Office for a copy of the publication.

**If all supplies have been exhausted—as indicated by two asterisks—contact your local "Depository Library," which should have received a printed or microformed copy of the publication.

***If the Government Printing Office's supply has been exhausted—as indicated by three asterisks—a single copy may be obtained from the committee.

While a single copy of a publication is available, free of charge, from the committee, the Government Printing Office charges for publications. When ordering a publication from the Government Printing Office, give title of publication and attach a check or money order for the amount of purchase, made payable to: Government Printing Office.

In requesting printed copies of publications, please enclose a self-addressed label.

## ADDRESSES FOR REQUESTING PUBLICATIONS

Documents
Special Committee on Aging
U.S. Senate
Room SD-G37
Washington, D.C. 20510

Superintendent of Documents
Government Printing Office
Washington, D.C. 20402

## REPORTS

Action for the Aged and Aging, Report No. 128, March 1961.**
Action for the Aged and Aging, summary and recommendations of Report No. 128, 1961.**
Developments in Aging, 1959-63, Report No. 8, February 1963.**
Developments in Aging, 1963-64, Report No. 124, March 1965.**
Developments in Aging, 1965, Report No. 1073, March 15, 1966.**
Developments in Aging, 1966, Report No. 169, April 1967.**
Developments in Aging, 1967, Report No. 1098, April 1968.**
Developments in Aging, 1968, Report No. 91-119, April 1969.**
Developments in Aging, 1969, Report No. 91-875, February 1970.**
Developments in Aging, 1970, Report No. 92-46, March 1971.**
Developments in Aging, 1971 and January-March 1972, Report No. 92-784, April 1972.**
Developments in Aging: 1972 and January-March 1973, Report No. 93-147, March 1973.**
Developments in Aging: 1973 and January-March 1974, Report No. 93-846, May 1974.**
Developments in Aging: 1974 and January-April 1975, Report No. 94-250, June 1975.**
Developments in Aging: 1975 and January-May 1976—Part 1, Report No. 94-998, June 1976.**
Developments in Aging: 1975 and January-May 1976—Part 2, Report No. 94-998, 1976.**
Developments in Aging: 1976—Part 1, Report No. 95-88, March 1977.**
Developments in Aging: 1976—Part 2, Report No. 95-88, March 1977.**
Developments in Aging: 1977—Part 1, Report No. 95-771, April 1978.**
Developments in Aging: 1977—Part 2, Report No. 95-771, April 1978.**
Developments in Aging: 1978—Part 1, Report No. 96-55, March 1979—$6.50.*
Developments in Aging: 1978—Part 2, Report No. 96-55, March 1979—$6.50.*
Developments in Aging: 1979—Part 1, Report No. 96-613, February 1980.**
Developments in Aging: 1979—Part 2, Report No. 96-613, February 1980—$7.*
Developments in Aging: 1980—Part 1, Report No. 97-62, April 1981—$6.50.*
Developments in Aging: 1980—Part 2, Report No. 97-62, April 1981.**
Developments in Aging: 1981—Part 1, Report No. 97-314, February 1982.**
Developments in Aging: 1981—Part 2, Report No. 97-314, February 1982.***
Developments in Aging: 1982—Part 1, Report No. 98-13, February 1983—$10.

---

NOTE: When requesting or ordering publications in this listing, it is important that you first read the instructions on page 1.

Developments in Aging: 1982—Part 2, Report No. 98-13, February 1983—$7.

Comparison of Health Insurance Proposals for Older Persons, 1961, committee print, April 3, 1961.**

The 1961 White House Conference on Aging, basic policy statements and recommendations, committee print, May 15, 1961.**

New Population Facts on Older Americans, 1960, staff report, committee print, May 24, 1961.**

Basic Facts on the Health and Economic Status of Older Americans, staff report, committee print, June 2, 1961.**

Health and Economic Conditions of the American Aged, chart book, committee print, June 1961.**

State Action To Implement Medical Programs for the Aged, staff report, committee print, June 8, 1961.**

A Constant Purchasing Power Bond: A Proposal for Protecting Retirement Income, committee print, August 1961.**

Mental Illness Among Older Americans, committee print, September 8, 1961.**

Comparison of Health Insurance Proposals for Older Persons, 1961-62, committee print, May 10, 1962.**

Background Facts on the Financing of the Health Care of the Aged, committee print, excerpts from the report of the Division of Program Research, Social Security Administration, Department of Health, Education, and Welfare, May 24, 1962.**

Statistics on Older People: Some Current Facts About the Nation's Older People, June 14, 1962.**

Performance of the States: 18 Months of Experience With the Medical Assistance for the Aged (Kerr-Mills) Program, committee print report, June 15, 1962.**

Housing for the Elderly, committee print report, August 31, 1962.**

Some Current Facts About the Nation's Older People, October 2, 1962.**

A Compilation of Materials Relevant to the Message of the President of the United States on Our Nation's Senior Citizens, committee print, June 1963.**

Medical Assistance for the Aged: The Kerr-Mills Program, 1960-63, committee print report, October 1963.**

Blue Cross and Private Health Insurance Coverage of Older Americans, committee print report, July 1964.**

Increasing Employment Opportunities for the Elderly—Recommendations and Comment, committee print report, August 1964.**

Services for Senior Citizens—Recommendations and Comment, Report No. 1542, September 1964.**

Major Federal Legislative and Executive Action Affecting Senior Citizens, 1963-64, staff report, committee print, October 1964.**

Frauds and Deceptions Affecting the Elderly—Investigations, Findings, and Recommendations, 1964, committee print report, January 1965.**

Extending Private Pension Coverage, committee print report, June 1965.**

---

NOTE: When requesting or ordering publications in this listing, it is important that you first read the instructions on page 1.

Health Insurance and Related Provisions of Public Law 89-97: The Social Security Amendments of 1965, committee print, October 1965.**

Major Federal Legislative and Executive Actions Affecting Senior Citizens, 1965, staff report, committee print, November 1965.**

Services to the Elderly on Public Assistance, committee print report, March 1966.**

The War on Poverty As It Affects the Elderly, Report No. 1287, June 1966.**

Needs for Services Revealed by Operation Medicare Alert, committee print report, October 1966.**

Tax Consequences of Contributions to Needy Older Relatives, Report No. 1721, October 13, 1966.**

Detection and Prevention of Chronic Disease Utilizing Multiphasic Health Screening Techniques, committee print report, December 30, 1966.**

Reduction of Retirement Benefits Due to Social Security Increases, committee print report, August 21, 1967.**

Economics of Aging: Toward a Full Share in Abundance, working paper, committee print, March 1969.** [1]

Homeownership Aspects of the Economics of Aging, working paper, factsheet, July 1969.** [1]

Health Aspects of the Economics of Aging, working paper, committee print, July 1969 (revised).** [1]

Social Security for the Aged: International Perspectives, working paper, committee print, August 1969.** [1]

Employment Aspects of the Economics of Aging, working paper, committee print, December 1969.** [1]

Pension Aspects of the Economics of Aging: Present and Future Roles of Private Pensions, working paper, committee print, January 1970.** [1]

The Stake of Today's Workers in Retirement Security, working paper, committee print, April 1970.** [1]

Legal Problems Affecting Older Americans, working paper, committee print, August 1970.** [1]

Income Tax Overpayments by the Elderly, Report No. 91-1464, December 1970.**

Older Americans and Transportation: A Crisis in Mobility, Report No. 91-1520, December 1970.**

Economics of Aging: Toward a Full Share in Abundance, Report No. 91-1548, December 31, 1970.**

Medicare, Medicaid Cutbacks in California, working paper, factsheet, May 10, 1971.** [1]

The Nation's Stake in the Employment of Middle-Aged and Older Persons, working paper, committee print, July 1971.**

The Administration on Aging—Or a Successor?, committee print report, October 1971.**

Alternatives to Nursing Home Care: A Proposal, committee print, October 1971.**

---

[1] Working paper incorporated as an appendix to the hearing.

NOTE: When requesting or ordering publications in this listing, it is important that you first read the instructions on page 1.

Mental Health Care and the Elderly: Shortcomings in Public Policy, Report No. 92-433, November 1971.**

The Multiple Hazards of Age and Race: The Situation of Aged Blacks in the United States, Report No. 92-450, November 1971.**

Advisory Council on the Elderly American Indian, working paper, committee print, November 1971.**

Elderly Cubans in Exile, working paper, committee print, November 1971.**

A Pre-White House Conference on Aging: Summary of Developments and Data, Report No. 92-505, November 1971.**

Research and Training in Gerontology, working paper, committee print, November 1971.**

Making Services for the Elderly Work: Some Lessons From the British Experience, committee print report, November 1971.**

1971 White House Conference on Aging, a report to the delegates from the conference sections and special concerns sessions, December 1971.**

Home Health Services in the United States, committee print report, April 1972.**

Proposals To Eliminate Legal Barriers Affecting Elderly Mexican-Americans, working paper, committee print, May 1972.**

Cancelled Careers: The Impact of Reduction-in-Force Policies on Middle-Aged Federal Employees, committee print report, May 1972.**

Action on Aging Legislation in 92d Congress, committee print, October 1972.**

Legislative History of the Older Americans Comprehensive Services Amendments of 1972, joint committee print, prepared by the Subcommittee on Aging of the Committee on Labor and Public Welfare and the Special Committee on Aging, December 1972.**

The Rise and Threatened Fall of Service Programs for the Elderly, report by the Subcommittee on Federal, State, and Community Services, Report No. 93-94, March 28, 1973.**

Housing for the Elderly: A Status Report, working paper, committee print, April 1973.**

Older Americans Comprehensive Services Amendments of 1973, committee print, June 1973.**

Home Health Services in the United States: A Working Paper on Current Status, committee print, July 1973.**

Economics of Aging: Toward a Full Share in Abundance, index to hearings and reports, committee print, July 1973.**

Research on Aging Act, 1973, Report No. 93-299, committee print, July 1973.**

Post-White House Conference on Aging Reports, 1973, joint committee print, prepared by the Subcommittee on Aging of the Committee on Labor and Public Welfare and the Special Committee on Aging, September 1973.**

Improving the Age Discrimination Law, working paper, committee print, September 1973.**

---

NOTE: When requesting or ordering publications in this listing, it is important that you first read the instructions on page 1.

The Proposed Fiscal 1975 Budget: What It Means for Older Americans, committee print, February 1974.**

Protecting Older Americans Against Overpayment of Income Taxes: A Checklist of Itemized Deductions, committee print, February 1974.**

Developments and Trends in State Programs and Services for the Elderly, committee print report, November 1974.**

Nursing Home Care in the United States: Failure in Public Policy, reports by the Subcommittee on Long-Term Care:**

Introductory Report, Report No. 93-1420, November 1974.

Supporting Paper No. 1, "The Litany of Nursing Home Abuses and an Examination of the Roots of Controversy," committee print report, December 1974.

Supporting Paper No. 2, "Drugs in Nursing Homes: Misuse, High Costs, and Kickbacks," committee print report, January 1975.

Supporting Paper No. 3, "Doctors in Nursing Homes: The Shunned Responsibility," committee print report, February 1975.

Supporting Paper No. 4, "Nurses in Nursing Homes: The Heavy Burden (the Reliance on Untrained and Unlicensed Personnel)," committee print report, April 1975.

Supporting Paper No. 5, "The Continuing Chronicle of Nursing Home Fires," committee print report, August 1975.

Supporting Paper No. 6, "What Can Be Done in Nursing Homes: Positive Aspects in Long-Term Care," committee print report, September 1975.

Supporting Paper No. 7, "The Role of Nursing Homes in Caring for Discharged Mental Patients (and the Birth of a For-Profit Boarding Home Industry)," committee print report, March 1976.

Private Health Insurance Supplementary to Medicare, working paper, committee print, December 1974.**

Protecting Older Americans Against Overpayment of Income Taxes, committee print, January 1975.**

Senior Opportunities and Services (Directory of Programs), committee print, February 1975.**

Action on Aging Legislation in 93d Congress, committee print, February 1975.**

The Proposed Fiscal 1976 Budget: What It Means for Older Americans, committee print, February 1975.**

Future Directions in Social Security: An Interim Report, committee print, March 1975.**

Women and Social Security: Adapting to a New Era, working paper, committee print, October 1975.**

Congregate Housing for Older Adults, Report No. 94-478, November 1975.**

Protecting Older Americans Against Overpayment of Income Taxes, committee print, January 1976.**

The Proposed Fiscal 1977 Budget: What It Means for Older Americans, committee print, February 1976.**

---

NOTE: When requesting or ordering publications in this listing, it is important that you first read the instructions on page 1.

Fraud and Abuse Among Clinical Laboratories, Report No. 94-944, June 15, 1976.**

Recession's Continuing Victim: The Older Worker, committee print, July 1976.**

Fraud and Abuse Among Practitioners Participating in the Medicaid Program, committee print, August 1976, stock No. 052-070-03647-8—$6.50.*

Adult Day Facilities for Treatment, Health Care, and Related Services, committee print, September 1976.**

Termination of Social Security Coverage: The Impact on State and Local Government Employees, committee print, September 1976.**

Witness Index and Research Reference, committee print, November 1976.**

Action on Aging Legislation in 94th Congress, committee print, November 1976.**

Protecting Older Americans Against Overpayment of Income Taxes, committee print, December 1976.**

The Proposed Fiscal 1978 Budget: What It Means for Older Americans, committee print, March 1977.**

Kickbacks Among Medicaid Providers, Report No. 95-320, June 1977.**

Protective Services for the Elderly, committee print, July 1977, stock No. 052-070-04120-0—$5.*

The Next Steps in Combating Age Discrimination in Employment: With Special Reference to Mandatory Retirement Policy, committee print, August 1977.**

Protecting Older Americans Against Overpayment of Income Taxes, committee print, December 1977.**

The Proposed Fiscal 1979 Budget: What It Means for Older Americans, committee print, February 1978.**

Paperwork and the Older Americans Act: Problems of Implementing Accountability, committee print, June 1978, stock No. 052-070-04539-6—$4.50.*

Single Room Occupancy: A Need for National Concern, committee print, June 1978.**

Protecting Older Americans Against Overpayment of Income Taxes, committee print, December 1978.**

Action on Aging Legislation in the 95th Congress, committee print, December 1978.**

The Proposed Fiscal 1980 Budget: What It Means for Older Americans, committee print, February 1979.**

Energy Assistance Programs and Pricing Policies in the 50 States To Benefit Elderly, Disabled, or Low-Income Households, committee print, October 1979.**

Witness Index and Research Reference, committee print, November 1979.**

Protecting Older Americans Against Overpayment of Income Taxes, committee print, January 1980.**

The Proposed Fiscal 1981 Budget: What It Means for Older Americans, committee print, February 1980.**

---

NOTE: When requesting or ordering publications in this listing, it is important that you first read the instructions on page 1.

Emerging Options for Work and Retirement Policy (An Analysis of Major Income and Employment Issues With an Agenda for Research Priorities), committee print, June 1980, stock No. 052-070-05332-1—$5.50.*

Summary of Recommendations and Surveys on Social Security and Pension Policies, committee print, October 1980, stock No. 052-070-05443-3—$4.25.*

Innovative Developments in Aging: State Level, committee print, October 1980, stock No. 052-070-05447-6—$7.50.*

State Offices on Aging: History and Statutory Authority, committee print, December 1980, stock No. 052-070-05495-6—$4.25.*

Protecting Older Americans Against Overpayment of Income Taxes, committee print, December 1980.**

State and Local Government Terminations of Social Security Coverage, committee print, December 1980, stock No. 052-070-05502-2—$4.75.*

The Proposed Fiscal Year 1982 Budget: What It Means for Older Americans, committee print, April 1981.***

Action on Aging Legislation in the 96th Congress, committee print, April 1981.***

Energy and the Aged, committee print, August 1981.**

1981 Federal Income Tax Legislation: How It Affects Older Americans and Those Planning Retirement, committee print, August 1981, stock No. 052-070-05624-0—$2.25.

Omnibus Budget Reconciliation Act of 1981, Public Law 97-35 (Selected Provisions Affecting the Elderly), committee print, September 1981, stock No. 052-070-05632-1—$2.50.*

Toward a National Older Worker Policy, committee print, September 1981, stock No. 052-070-05634-7—$4.25.

Crime and the Elderly—What You Can Do, committee print, September 1981.**

Social Security in Europe: The Impact of an Aging Population, committee print, December 1981, stock No. 052-070-05655-0—$3.

Background Materials Relating to Office of Inspector General, Department of Health and Human Services Efforts To Combat Fraud, Waste, and Abuse, committee print, December 1981.**

Protecting Older Americans Against Overpayment of Income Taxes, committee print, December 1981, stock No. 052-070-05665-7—$2.25.*

A Guide to Individual Retirement Accounts (IRA's), committee print, December 1981, stock No. 052-070-05666-5—$2.

Social Security Disability: Past, Present, and Future, committee print, March 1982, stock No. 052-070-05694-1—$3.

The Proposed Fiscal Year 1983 Budget: What It Means for Older Americans, March 1982.***

Linkages Between Private Pensions and Social Security Reform, committee print, April 1982, stock No. 052-070-05718-1—$2.75.*

Health Care Expenditures for the Elderly: How Much Protection Does Medicare Provide?, committee print, April 1982, stock No. 052-070-05723-8—$2.*

---

NOTE: When requesting or ordering publications in this listing, it is important that you first read the instructions on page 1.

Turning Home Equity Into Income for Older Americans, committee print, July 1982, stock No. 052-070-05753-0—$3.

Aging and the Work Force: Human Resource Strategies, committee print, August 1982, stock No. 052-070-05767-0—$4.50.

Fraud, Waste, and Abuse in the Medicare Pacemaker Industry, committee print, September 1982, stock No. 052-070-05777-7—$6.**

Congressional Action on the Fiscal Year 1983 Budget: What It Means for Older Americans, committee print, November 1982.***

Equal Employment Opportunity Commission Enforcement of the Age Discrimination in Employment Act: 1978 to 1982, committee print, November 1982.***

Protecting Older Americans Against Overpayment of Income Taxes, committee print, December 1982, stock No. 052-070-05795-5—$3.

---

NOTE: When requesting or ordering publications in this listing, it is important that you first read the instructions on page 1.

## HEARINGS

Retirement Income of the Aging:**
- Part 1. Washington, D.C., July 12-13, 1961.
- Part 2. St. Petersburg, Fla., November 6, 1961.
- Part 3. Port Charlotte, Fla., November 7, 1961.
- Part 4. Sarasota, Fla., November 8, 1961.
- Part 5. Springfield, Mass., November 29, 1961.
- Part 6. St. Joseph, Mo., December 11, 1961.
- Part 7. Hannibal, Mo., December 13, 1961.
- Part 8. Cape Girardeau, Mo., December 15, 1961.
- Part 9. Daytona Beach, Fla., February 14, 1962.
- Part 10. Fort Lauderdale, Fla., February 15, 1962.

Housing Problems of the Elderly:**
- Part 1. Washington, D.C., August 22-23, 1961.
- Part 2. Newark, N.J., October 16, 1961.
- Part 3. Philadelphia, Pa., October 18, 1961.
- Part 4. Scranton, Pa., November 14, 1961.
- Part 5. St. Louis, Mo., December 8, 1961.

Problems of the Aging (Federal-State activities):**
- Part 1. Washington, D.C., August 23-24, 1961.
- Part 2. Trenton, N.J., October 23, 1961.
- Part 3. Los Angeles, Calif., October 24, 1961.
- Part 4. Las Vegas, Nev., October 25, 1961.
- Part 5. Eugene, Oreg., November 8, 1961.
- Part 6. Pocatello, Idaho, November 13, 1961.
- Part 7. Boise, Idaho, November 15, 1961.
- Part 8. Spokane, Wash., November 17, 1961.
- Part 9. Honolulu, Hawaii, November 27, 1961.
- Part 10. Lihue, Hawaii, November 29, 1961.
- Part 11. Wailuku, Hawaii, November 30, 1961.
- Part 12. Hilo, Hawaii, December 1, 1961.
- Part 13. Kansas City, Mo., December 6, 1961.

Nursing Homes:**
- Part 1. Portland, Oreg., November 6, 1961.
- Part 2. Walla Walla, Wash., November 10, 1961.
- Part 3. Hartford, Conn., November 20, 1961.
- Part 4. Boston, Mass., December 1, 1961.
- Part 5. Minneapolis, Minn., December 4, 1961.
- Part 6. Springfield, Mo., December 12, 1961.

Relocation of Elderly People:**
- Part 1. Washington, D.C., October 22-23, 1962.
- Part 2. Newark, N.J., October 26, 1962.
- Part 3. Camden, N.J., October 29, 1962.
- Part 4. Portland, Oreg., December 3, 1962.

---

**NOTE: When requesting or ordering publications in this listing, it is important that you first read the instructions on page 1.**

Relocation of Elderly People—Continued
  Part 5. Los Angeles, Calif., December 5, 1962.
  Part 6. San Francisco, Calif., December 7, 1962.
Frauds and Quackery Affecting the Older Citizen:**
  Part 1. Washington, D.C., January 15, 1963.
  Part 2. Washington, D.C., January 16, 1963.
  Part 3. Washington, D.C., January 17, 1963.
Housing Problems of the Elderly:**
  Part 1. Washington, D.C., December 11, 1963.
  Part 2. Los Angeles, Calif., January 9, 1964.
  Part 3. San Francisco, Calif., January 11, 1964.
Long-Term Institutional Care for the Aged (Federal programs), Washington, D.C., December 17–18, 1963.**
Increasing Employment Opportunities for the Elderly:**
  Part 1. Washington, D.C., December 19, 1963.
  Part 2. Los Angeles, Calif., January 10, 1964.
  Part 3. San Francisco, Calif., January 13, 1964.
Health Frauds and Quackery:**
  Part 1. San Francisco, Calif., January 13, 1964.
  Part 2. Washington, D.C., March 9, 1964.
  Part 3. Washington, D.C., March 10, 1964.
  Part 4A. Washington, D.C., April 6, 1964 (eye care).
  Part 4B. Washington, D.C., April 6, 1964 (eye care).
Services for Senior Citizens:**
  Part 1. Washington, D.C., January 16, 1964.
  Part 2. Boston, Mass., January 20, 1964.
  Part 3. Providence, R.I., January 21, 1964.
  Part 4. Saginaw, Mich., March 2, 1964.
Blue Cross and Other Private Health Insurance for the Elderly:**
  Part 1. Washington, D.C., April 27, 1964.
  Part 2. Washington, D.C., April 28, 1964.
  Part 3. Washington, D.C., April 29, 1964.
  Part 4A. Appendix.
  Part 4B. Appendix.
Deceptive or Misleading Methods in Health Insurance Sales, Washington, D.C., May 4, 1964.**
Nursing Homes and Related Long-Term Care Services:**
  Part 1. Washington, D.C., May 5, 1964.
  Part 2. Washington, D.C., May 6, 1964.
  Part 3. Washington, D.C., May 7, 1964.
Interstate Mail Order Land Sales:**
  Part 1. Washington, D.C., May 18, 1964.
  Part 2. Washington, D.C., May 19, 1964.
  Part 3. Washington, D.C., May 20, 1964.
Preneed Burial Service, Washington, D.C., May 19, 1964.**
Conditions and Problems in the Nation's Nursing Homes:**
  Part 1. Indianapolis, Ind., February 11, 1965.
  Part 2. Cleveland, Ohio, February 15, 1965.
  Part 3. Los Angeles, Calif., February 17, 1965.
  Part 4. Denver, Colo., February 23, 1965.
  Part 5. New York, N.Y., August 2–3, 1965.

---

NOTE: When requesting or ordering publications in this listing, it is important that you first read the instructions on page 1.

Conditions and Problems in the Nation's Nursing Homes—Continued
  Part 6. Boston, Mass., August 9, 1965.
  Part 7. Portland, Maine, August 13, 1965.
Extending Private Pension Coverage:**
  Part 1. Washington, D.C., March 4, 1965.
  Part 2. Washington, D.C., March 5 and 10, 1965.
The War on Poverty As It Affects Older Americans:**
  Part 1. Washington, D.C., June 16-17, 1965.
  Part 2. Newark, N.J., July 10, 1965.
  Part 3. Washington, D.C., January 19-20, 1966.
Services to the Elderly on Public Assistance:**
  Part 1. Washington, D.C., August 18-19, 1965.
  Part 2. Appendix.
Needs for Services Revealed by Operation Medicare Alert, Washington, D.C., June 2, 1966.**
Tax Consequences of Contributions to Needy Older Relatives, Washington, D.C., June 15, 1966.**
Detection and Prevention of Chronic Disease Utilizing Multiphasic Health Screening Techniques, Washington, D.C., September 20, 21, and 22, 1966.**
Consumer Interests of the Elderly:**
  Part 1. Washington, D.C., January 17-18, 1967.
  Part 2. Tampa, Fla., February 2-3, 1967.
Reduction of Retirement Benefits Due to Social Security Increases, Washington, D.C., April 24-25, 1967.**
Retirement and the Individual:**
  Part 1. Washington, D.C., June 7-8, 1967.
  Part 2. Ann Arbor, Mich., July 26, 1967.
Costs and Delivery of Health Services to Older Americans:**
  Part 1. Washington, D.C., June 22-23, 1967.
  Part 2. New York, N.Y., October 19, 1967.
  Part 3. Los Angeles, Calif., October 16, 1968.
Rent Supplement Assistance to the Elderly, Washington, D.C., July 11, 1967.**
Long-Range Program and Research Needs in Aging and Related Fields, Washington, D.C., December 5-6, 1967.**
Hearing Loss, Hearing Aids, and the Elderly, Washington, D.C., July 18-19, 1968.**
Usefulness of the Model Cities Program to the Elderly:**
  Part 1. Washington, D.C., July 23, 1968.
  Part 2. Seattle, Wash., October 14, 1968.
  Part 3. Ogden, Utah, October 24, 1968.
  Part 4. Syracuse, N.Y., December 9, 1968.
  Part 5. Atlanta, Ga., December 11, 1968.
  Part 6. Boston, Mass., July 11, 1969.
  Part 7. Washington, D.C., October 14-15, 1969.
Adequacy of Services for Older Workers, Washington, D.C., July 24-25, and 29, 1968.**
Availability and Usefulness of Federal Programs and Services to Elderly Mexican-Americans:**
  Part 1. Los Angeles, Calif., December 17, 1968.

---

NOTE: When requesting or ordering publications in this listing, it is important that you first read the instructions on page 1.

Availability and Usefulness of Federal Programs and Services to Elderly Mexican-Americans—Continued
  Part 2. El Paso, Tex., December 18, 1968.
  Part 3. San Antonio, Tex., December 19, 1968.
  Part 4. Washington, D.C., January 14-15, 1969.
  Part 5. Washington, D.C., November 20-21, 1969.
Economics of Aging: Toward a Full Share in Abundance:**
  Part 1. Washington, D.C., April 29-30, 1969.
  Part 2. Ann Arbor, Mich., consumer aspects, June 9, 1969.
  Part 3. Washington, D.C., health aspects, July 17-18, 1969.
  Part 4. Washington, D.C., homeownership aspects, July 31 and August 1, 1969.
  Part 5. Paramus, N.J., central suburban area, August 14, 1969.
  Part 6. Cape May, N.J., retirement community, August 15, 1969.
  Part 7. Washington, D.C., international aspects, August 25, 1969.
  Part 8. Washington, D.C., national organizations, October 29, 1969.
  Part 9. Washington, D.C., employment aspects, December 18-19, 1969.
  Part 10A. Washington, D.C., pension aspects, February 17, 1970.
  Part 10B. Washington, D.C., pension aspects, February 18, 1970.
  Part 11. Washington, D.C., concluding hearing, May 4, 5, and 6, 1970.
The Federal Role in Encouraging Preretirement Counseling and New Work Lifetime Patterns, Washington, D.C., July 25, 1969.**
Trends in Long-Term Care:**
  Part 1. Washington, D.C., July 30, 1969.
  Part 2. St. Petersburg, Fla., January 9, 1970.
  Part 3. Hartford, Conn., January 15, 1970.
  Part 4. Washington, D.C. (Marietta, Ohio, fire), February 9, 1970.
  Part 5. Washington, D.C. (Marietta, Ohio, fire), February 10, 1970.
  Part 6. San Francisco, Calif., February 12, 1970.
  Part 7. Salt Lake City, Utah, February 13, 1970.
  Part 8. Washington, D.C., May 7, 1970.
  Part 9. Washington, D.C. (Salmonella), August 19, 1970.
  Part 10. Washington, D.C. (Salmonella), December 14, 1970.
  Part 11. Washington, D.C., December 17, 1970.
  Part 12. Chicago, Ill., April 2, 1971.
  Part 13. Chicago, Ill., April 3, 1971.
  Part 14. Washington, D.C., June 15, 1971.
  Part 15. Chicago, Ill., September 14, 1971.
  Part 16. Washington, D.C., September 29, 1971.
  Part 17. Washington, D.C., October 14, 1971.
  Part 18. Washington, D.C., October 28, 1971.
  Part 19A. Minneapolis-St. Paul, Minn., November 29, 1971.

---

**Note**: When requesting or ordering publications in this listing, it is important that you first read the instructions on page 1.

Trends in Long-Term Care—Continued
    Part 19B. Minneapolis-St. Paul, Minn., November 29, 1971.
    Part 20. Washington, D.C., August 10, 1972.
    Part 21. Washington, D.C., October 10, 1973.
    Part 22. Washington, D.C., October 11, 1973.
    Part 23. New York, N.Y., January 21, 1975.
    Part 24. New York, N.Y., February 4, 1975.
    Part 25. Washington, D.C., February 19, 1975.
    Part 26. Washington, D.C., December 9, 1975.
    Part 27. New York, N.Y., March 19, 1976.
Older Americans in Rural Areas:**
    Part 1. Des Moines, Iowa, September 8, 1969.
    Part 2. Majestic-Freeburn, Ky., September 12, 1969.
    Part 3. Fleming, Ky., September 12, 1969.
    Part 4. New Albany, Ind., September 16, 1969.
    Part 5. Greenwood, Miss., October 9, 1969.
    Part 6. Little Rock, Ark., October 10, 1969.
    Part 7. Emmett, Idaho, February 24, 1970.
    Part 8. Boise, Idaho, February 24, 1970.
    Part 9. Washington, D.C., May 26, 1970.
    Part 10. Washington, D.C., June 2, 1970.
    Part 11. Dogbone-Charleston, W. Va., October 27, 1970.
    Part 12. Wallace-Clarksburg, W. Va., October 28, 1970.
Income Tax Overpayments by the Elderly, Washington, D.C., April 15, 1970.**
Sources of Community Support for Federal Programs Serving Older Americans:**
    Part 1. Ocean Grove, N.J., April, 18, 1970.
    Part 2. Washington, D.C., June 8–9, 1970.
Legal Problems Affecting Older Americans:**
    St. Louis, Mo., August 11, 1970.
    Boston, Mass., April 30, 1971.
Evaluation of Administration on Aging and Conduct of White House Conference on Aging:**
    Part 1. Washington, D.C., March 25, 1971.
    Part 2. Washington, D.C., March 29, 1971.
    Part 3. Washington, D.C., March 30, 1971.
    Part 4. Washington, D.C., March 31, 1971.
    Part 5. Washington, D.C., April 27, 1971.
    Part 6. Orlando, Fla., May 10, 1971.
    Part 7. Des Moines, Iowa, May 13, 1971.
    Part 8. Boise, Idaho, May 28, 1971.
    Part 9. Casper, Wyo., August 13, 1971.
    Part 10. Washington, D.C., February 3, 1972.
Cutbacks in Medicare and Medicaid Coverage:**
    Part 1. Los Angeles, Calif., May 10, 1971.
    Part 2. Woonsocket, R.I., June 14, 1971.
    Part 3. Providence, R.I., September 20, 1971.
Unemployment Among Older Workers:**
    Part 1. South Bend, Ind., June 4, 1971.
    Part 2. Roanoke, Ala., August 10, 1971.

---

NOTE: When requesting or ordering publications in this listing, it is important that you first read the instructions on page 1.

Unemployment Among Older Workers—Continued
  Part 3. Miami, Fla., August 11, 1971.
  Part 4. Pocatello, Idaho, August 27, 1971.
Adequacy of Federal Response to Housing Needs of Older Americans:**
  Part 1. Washington, D.C., August 2, 1971.
  Part 2. Washington, D.C., August 3, 1971.
  Part 3. Washington, D.C., August 4, 1971.
  Part 4. Washington, D.C., October 28, 1971.
  Part 5. Washington, D.C., October 29, 1971.
  Part 6. Washington, D.C., July 31, 1972.
  Part 7. Washington, D.C., August 1, 1972.
  Part 8. Washington, D.C., August 2, 1972.
  Part 9. Boston, Mass., October 2, 1972.
  Part 10. Trenton, N.J., January 17, 1974.
  Part 11. Atlantic City, N.J., January 18, 1974.
  Part 12. East Orange, N.J., January 19, 1974.
  Part 13. Washington, D.C., October 7, 1975.
  Part 14. Washington, D.C., October 8, 1975.
Flammable Fabrics and Other Fire Hazards to Older Americans, Washington, D.C., October 12, 1971.**
A Barrier-Free Environment for the Elderly and the Handicapped:**
  Part 1. Washington, D.C., October 18, 1971.
  Part 2. Washington, D.C., October 19, 1971.
  Part 3. Washington, D.C., October 20, 1971.
Death With Dignity: An Inquiry Into Related Public Issues:**
  Part 1. Washington, D.C., August 7, 1972.
  Part 2. Washington, D.C., August 8, 1972.
  Part 3. Washington, D.C., August 9, 1972.
Future Directions in Social Security:**
  Part 1. Washington, D.C., January 15, 1973.
  Part 2. Washington, D.C., January 22, 1973.
  Part 3. Washington, D.C., January 23, 1973.
  Part 4. Washington, D.C., July 25, 1973.
  Part 5. Washington, D.C., July 26, 1973.
  Part 6. Twin Falls, Idaho, May 16, 1974.
  Part 7. Washington, D.C., July 15, 1974.
  Part 8. Washington, D.C., July 16, 1974.
  Part 9. Washington, D.C., March 18, 1975.
  Part 10. Washington, D.C., March 19, 1975.
  Part 11. Washington, D.C., March 20, 1975.
  Part 12. Washington, D.C., May 1, 1975.
  Part 13. San Francisco, Calif., May 15, 1975.
  Part 14. Los Angeles, Calif., May 16, 1975.
  Part 15. Des Moines, Iowa, May 19, 1975.
  Part 16. Newark, N.J., June 30, 1975.
  Part 17. Toms River, N.J., September 8, 1975.
  Part 18. Washington, D.C., October 22, 1975.
  Part 19. Washington, D.C., October 23, 1975.
  Part 20. Portland, Oreg., November 24, 1975.

---

NOTE: When requesting or ordering publications in this listing, it is important that you first read the instructions on page 1.

Future Directions in Social Security—Continued
  Part 21. Portland, Oreg., November 25, 1975.
  Part 22. Nashville, Tenn., December 6, 1975.
  Part 23. Boston, Mass., December 19, 1975.
  Part 24. Providence, R.I., January 26, 1976.
  Part 25. Memphis, Tenn., February 16, 1976.
Fire Safety in Highrise Buildings for the Elderly:**
  Part 1. Washington, D.C., February 27, 1973.
  Part 2. Washington, D.C., February 28, 1973.
Barriers to Health Care for Older Americans:**
  Part 1. Washington, D.C., March 5, 1973.
  Part 2. Washington, D.C., March 6, 1973.
  Part 3. Livermore Falls, Maine, April 23, 1973.
  Part 4. Springfield, Ill., May 16, 1973.
  Part 5. Washington, D.C., July 11, 1973.
  Part 6. Washington, D.C., July 12, 1973.
  Part 7. Coeur d'Alene, Idaho, August 4, 1973.
  Part 8. Washington, D.C., March 12, 1974.
  Part 9. Washington, D.C., March 13, 1974.
  Part 10. Price, Utah, April 20, 1974.
  Part 11. Albuquerque, N. Mex., May 25, 1974.
  Part 12. Santa Fe, N. Mex., May 25, 1974.
  Part 13. Washington, D.C., June 25, 1974.
  Part 14. Washington, D.C., June 26, 1974.
  Part 15. Washington, D.C., July 9, 1974.
  Part 16. Washington, D.C., July 17, 1974.
Training Needs in Gerontology:**
  Part 1. Washington, D.C., June 19, 1973.
  Part 2. Washington, D.C., June 21, 1973.
  Part 3. Washington, D.C., March 7, 1975.
Hearing Aids and the Older American:**
  Part 1. Washington, D.C., September 10, 1973.
  Part 2. Washington, D.C., September 11, 1973.
Transportation and the Elderly: Problems and Progress:**
  Part 1. Washington, D.C., February 25, 1974.
  Part 2. Washington, D.C., February 27, 1974.
  Part 3. Washington, D.C., February 28, 1974.
  Part 4. Washington, D.C., April 9, 1974.
  Part 5. Washington, D.C., July 29, 1975.
  Part 6. Washington, D.C., July 12, 1977.
Improving Legal Representation for Older Americans:**
  Part 1. Los Angeles, Calif., June 14, 1974.
  Part 2. Boston, Mass., August 30, 1976.
  Part 3. Washington, D.C., September 28, 1976.
  Part 4. Washington, D.C., September 29, 1976.
Establishing a National Institute on Aging, Washington, D.C., August 1, 1974.**
The Impact of Rising Energy Costs on Older Americans:**
  Part 1. Washington, D.C., September 24, 1974.
  Part 2. Washington, D.C., September 25, 1974.
  Part 3. Washington, D.C., November 7, 1975.

---

NOTE: When requesting or ordering publications in this listing, it is important that you first read the instructions on page 1.

The Impact of Rising Energy Costs on Older Americans—Continued
- Part 4. Washington, D.C., April 5, 1977.
- Part 5. Washington, D.C., April 7, 1977.
- Part 6. Washington, D.C., June 28, 1977.
- Part 7. Missoula, Mont., February 14, 1979.

The Older Americans Act and the Rural Elderly, Washington, D.C., April 28, 1975.**

Examination of Proposed Section 202 Housing Regulations:**
- Part 1. Washington, D.C., June 6, 1975.
- Part 2. Washington, D.C., June 26, 1975.

The Recession and the Older Worker, Chicago, Ill., August 14, 1975.**

Medicare and Medicaid Frauds:**
- Part 1. Washington, D.C., September 26, 1975.
- Part 2. Washington, D.C., November 13, 1975.
- Part 3. Washington, D.C., December 5, 1975.
- Part 4. Washington, D.C., February 16, 1976.
- Part 5. Washington, D.C., August 30, 1976.
- Part 6. Washington, D.C., August 31, 1976.
- Part 7. Washington, D.C., November 17, 1976.
- Part 8. Washington, D.C., March 8, 1977.
- Part 9. Washington, D.C., March 9, 1977.

Mental Health and the Elderly, Washington, D.C., September 29, 1975.**

Proprietary Home Health Care (joint hearing with the House Select Committee on Aging), Washington, D.C., October 28, 1975.**

Proposed USDA Food Stamp Cutbacks for the Elderly, Washington, D.C., November 3, 1975.**

The Tragedy of Nursing Home Fires: The Need for National Commitment for Safety (joint hearing with House Select Committee on Aging), Washington, D.C., June 3, 1976.**

The Nation's Rural Elderly:**
- Part 1. Winterset, Iowa, August 16, 1976.
- Part 2. Ottumwa, Iowa, August 16, 1976.
- Part 3. Gretna, Nebr., August 17, 1976.
- Part 4. Ida Grove, Iowa, August 17, 1976.
- Part 5. Sioux Falls, S. Dak., August 18, 1976.
- Part 6. Rockford, Iowa, August 18, 1976.
- Part 7. Denver, Colo., March 23, 1977.
- Part 8. Flagstaff, Ariz., November 5, 1977.
- Part 9. Tucson, Ariz., November 7, 1977.
- Part 10. Terre Haute, Ind., November 11, 1977.
- Part 11. Phoenix, Ariz., November 12, 1977.
- Part 12. Roswell, N. Mex., November 18, 1977.
- Part 13. Taos, N. Mex., November 19, 1977.
- Part 14. Albuquerque, N. Mex., November 21, 1977.
- Part 15. Pensacola, Fla., November 21, 1977.
- Part 16. Gainesville, Fla., November 22, 1977.
- Part 17. Champaign, Ill., December 13, 1977.

---

NOTE: When requesting or ordering publications in this listing, it is important that you first read the instructions on page 1.

Medicine and Aging: An Assessment of Opportunities and Neglect, New York, N.Y., October 13, 1976.**
Effectiveness of Food Stamps for Older Americans:**
  Part 1. Washington, D.C., April 18, 1977.
  Part 2. Washington, D.C., April 19, 1977.
Health Care for Older Americans: The "Alternatives" Issue:**
  Part 1. Washington, D.C., May 16, 1977.
  Part 2. Washington, D.C., May 17, 1977.
  Part 3. Washington, D.C., June 15, 1977.
  Part 4. Cleveland, Ohio, July 6, 1977.
  Part 5. Washington, D.C., September 21, 1977.
  Part 6. Holyoke, Mass., October 12, 1977.
  Part 7. Tallahassee, Fla., November 23, 1977.
  Part 8. Washington, D.C., April 17, 1978.
Senior Centers and the Older Americans Act, Washington, D.C., October 18, 1977.**
The Graying of Nations: Implications, Washington, D.C., November 10, 1977.**
Tax Forms and Tax Equity for Older Americans, Washington, D.C., February 24, 1978.**
Medi-Gap: Private Health Insurance Supplements to Medicare:**
  Part 1. Washington, D.C., May 16, 1978.
  Part 2. Washington, D.C., June 29, 1978.
Retirement, Work, and Lifelong Learning:**
  Part 1. Washington, D.C., July 17, 1978.
  Part 2. Washington, D.C., July 18, 1978.
  Part 3. Washington, D.C., July 19, 1978.
  Part 4. Washington, D.C., September 8, 1978.
Medicaid Anti-Fraud Programs: The Role of State Fraud Control Units, Washington, D.C., July 25, 1978.**
Vision Impairment Among Older Americans, Washington, D.C., August 3, 1978.**
The Federal-State Effort in Long-Term Care for Older Americans: Nursing Homes and "Alternatives," Chicago, Ill., August 30, 1978, stock No. 052-070-05042-0—$4.50.*
Condominiums and the Older Purchaser:**
  Part 1. Hallandale, Fla., November 28, 1978.
  Part 2. West Palm Beach, Fla., November 29, 1978.
Older Americans in the Nation's Neighborhoods:**
  Part 1. Washington, D.C., December 1, 1978.
  Part 2. Oakland, Calif., December 4, 1978.
Commodities and Nutrition Program for the Elderly, Missoula, Mont., February 14, 1979.**
The Effect of Food Stamp Cutbacks on Older Americans, Washington, D.C., April 11, 1979.**
Home Care Services for Older Americans: Planning for the Future, Washington, D.C., May 7 and 21, 1979.**
Federal Paperwork Burdens, With Emphasis on Medicare (joint hearing with Subcommittee on Federal Spending Practices and Open Government of the Senate Committee on Governmental Affairs), St. Petersburg, Fla., August 6, 1979.**

---

NOTE: When requesting or ordering publications in this listing, it is important that you first read the instructions on page 1.

Abuse of the Medicare Home Health Program, Miami, Fla., August 28, 1979.**

Occupational Health Hazards of Older Workers in New Mexico, Grants, N. Mex., August 30, 1979.**

Energy Assistance for the Elderly:**

- Part 1. Akron, Ohio, August 30, 1979.
- Part 2. Washington, D.C., September 13, 1979.
- Part 3. Pennsauken, N.J., May 23, 1980.
- Part 4. Washington, D.C., July 25, 1980 (joint hearing with Subcommittee on Aging of the Senate Committee on Labor and Human Resources).

Regulations To Implement the Comprehensive Older Americans Act Amendments of 1978:**

- Part 1. Washington, D.C., October 18, 1979 (joint hearing with Subcommittee on Aging of the Senate Committee on Labor and Human Resources).
- Part 2. Washington, D.C., March 24, 1980.

Medicare Reimbursement for Elderly Participation in Health Maintenance Organizations and Health Benefit Plans, Philadelphia, Pa., October 29, 1979.**

Energy and the Aged: A Challenge to the Quality of Life in a Time of Declining Energy Availability, Washington, D.C., November 26, 1979.**

Adapting Social Security to a Changing Work Force, Washington, D.C., November 28, 1979.**

Aging and Mental Health: Overcoming Barriers to Service:**

- Part 1. Little Rock, Ark., April 4, 1980.
- Part 2. Washington, D.C., May 22, 1980.

Rural Elderly—The Isolated Population: A Look at Services in the 80's, Las Vegas, N. Mex., April 11, 1980.**

Work After 65: Options for the 80's:*

- Part 1. Washington, D.C., April 24, 1980, stock No. 052-070-05358-5—$4.50.
- Part 2. Washington, D.C., May 13, 1980, stock No. 052-070-05403-4—$4.75.
- Part 3. Orlando, Fla., July 9, 1980, stock No. 052-070-05468-9—$4.50.

How Old Is "Old"? The Effects of Aging on Learning and Working, Washington, D.C., April 30, 1980, stock No. 052-070-05469-7—$4.50.*

Minority Elderly: Economics and Housing in the 80's, Philadelphia, Pa., May 7, 1980.**

Maine's Rural Elderly: Independence Without Isolation, Bangor, Maine, June 9, 1980.**

Elder Abuse, Washington, D.C., June 11, 1980 (joint hearing with House Select Committee on Aging).**

Crime and the Elderly: What Your Community Can Do, Albuquerque, N. Mex., June 23, 1980, stock No. 052-070-05517-1—$5.*

Possible Abuse and Maladministration of Home Rehabilitation Programs for the Elderly, Santa Fe, N. Mex., October 8, 1980, and Washington, D.C., December 19, 1980.**

---

**Note:** When requesting or ordering publications in this listing, it is important that you first read the instructions on page 1.

Energy Equity and the Elderly in the 80's:**
    Part 1. Boston, Mass., October 24, 1980.
    Part 2. St. Petersburg, Fla., October 28, 1980.
Retirement Benefits: Are They Fair and Are They Enough?, Fort Leavenworth, Kans., November 8, 1980.**
Social Security: What Changes Are Necessary?**
    Part 1. Washington, D.C., November 21, 1980.
    Part 2. Washington, D.C., December 2, 1980.
    Part 3. Washington, D.C., December 3, 1980.
    Part 4. Washington, D.C., December 4, 1980.
Home Health Care: Future Policy (joint hearing with Senate Committee on Labor and Human Resources), Princeton, N.J., November 23, 1980.**
Impact of Federal Estate Tax Policies on Rural Women, Washington, D.C., February 4, 1981.***
Impact of Federal Budget Proposals on Older Americans:***
    Part 1. Washington, D.C., March 20, 1981.
    Part 2. Washington, D.C., March 27, 1981.
    Part 3. Philadelphia, Pa., April 10, 1981.
Energy and the Aged, Washington, D.C., April 9, 1981.**
Older Americans Act, Washington, D.C., April 27, 1981.***
Social Security Reform: Effect on Work and Income After Age 65, Rogers, Ark., May 18, 1981.**
Social Security Oversight:**
    Part 1 (Short-Term Financing Issues). Washington, D.C., June 16, 1981.
    Part 2 (Early Retirement). Washington, D.C., June 18, 1981.
    Part 3 (Cost-of-Living Adjustments). Washington, D.C., June 24, 1981.
Medicare Reimbursement to Competitive Medical Plans, Washington, D.C., July 29, 1981.***
Rural Access to Elderly Programs, Sioux Falls, S. Dak., August 3, 1981.**
Frauds Against the Elderly, Harrisburg, Pa., August 4, 1981.***
The Social Security System: Averting the Crisis, Evanston, Ill., August 10, 1981.***
Social Security Reform and Retirement Income Policy, Washington, D.C., September 16, 1981.***
Older Americans Fighting the Fear of Crime, Washington, D.C., September 22, 1981.**
Employment: An Option for All Ages, Rock Island, Ill., and Davenport, Iowa, October 12, 1981.***
Older Workers: The Federal Role in Promoting Employment Opportunities, Washington, D.C., October, 29, 1981.***
Rural Health Care for the Elderly: New Paths for the Future, Grand Forks, N. Dak., November 14, 1981.**
Oversight of HHS Inspector General's Effort To Combat Fraud, Waste and Abuse (joint hearing with Senate Finance Committee), Washington, D.C., December 9, 1981.***
Alternative Approaches To Housing Older Americans, Hartford, Conn., February 1, 1982.***

---

NOTE: When requesting or ordering publications in this listing, it is important that you first read the instructions on page 1.

Energy and the Aged: The Widening Gap, Erie, Pa., February 19, 1982.***

Hunger, Nutrition, Older Americans: The Impact of the Fiscal *Year 1983 Budget, Washington, D.C.*, February 25, 1982.***

Problems Associated With the Medicare Reimbursement System for Hospitals, Washington, D.C., March 10, 1982.***

Impact of the Federal Budget on the Future of Services for Older Americans, Washington, D.C., April 1, 1982 (joint hearing with House Select Committee on Aging).***

Health Care for the Elderly: What's In the Future for Long-Term Care?, Bismarck, N. Dak., April 6, 1982.***

The Impact of the Administration's Housing Proposals on Older Americans, Washington, D.C., April 23, 1982.***

Rural Older Americans: Unanswered Questions, Washington, D.C., May 19, 1982.***

The Hospice Alternative, Pittsburgh, Pa., May 24, 1982.***

Nursing Home Survey and Certification: Assuring Quality Care, Washington, D.C., July 15, 1982.***

Opportunities in Home Equity Conversion for the Elderly, Washington, D.C., July 20, 1982.***

Long-Term Health Care for the Elderly, Newark, N.J., July 26, 1982.***

Fraud, Waste, and Abuse in the Medicare Pacemaker Industry, Washington, D.C., September 10, 1982.***

Social Security Disability: The Effects of Accelerated Review, Fort Smith, Ark., November 19, 1982 (joint hearing with the Subcommittee on Civil Service, Post Office, and General Services of the Senate Committee on Governmental Affairs).***

Quality Assurance Under Prospective Reimbursement Programs, Washington, D.C., February 4, 1983.***

Combating Frauds Against the Elderly, Washington, D.C., March 1, 1983.***

Energy and the Aged: The Impact of Natural Gas Deregulation, Washington, D.C., March 17, 1983.***

Social Security Reviews of the Mentally Disabled, Washington, D.C., April 7, 8, 1983.***

The Future of Medicare, Washington, D.C., April 13, 1983.***

Life Care Communities: Promises and Problems, Washington, D.C., May 25, 1983.

Drug Use and Misuse: A Growing Concern for Older Americans, Washington, D.C., June 28, 1983.***

Community Alternatives To Institutional Care, Harrisburg, Pa., July 6, 1983.***

Crime and the Elderly, Los Angeles, Calif., July 6, 1983.***

Home Fire Deaths: A Preventable Tragedy, Washington, D.C., July 28, 1983.***

---

NOTE: When requesting or ordering publications in this listing, it is important that you first read the instructions on page 1.

The Role of Nursing Homes in Today's Society, Sioux Falls, S. Dak., August 29, 1983.***
Endless Night, Endless Mourning: Living With Alzheimer's, New York, N.Y., September 12, 1983.
Controlling Health Care Costs: State, Local, and Private Sector Initiatives, Washington, D.C., October 26, 1983.***
Social Security: How Well Is It Serving the Public?, Washington, D.C., November 29, 1983.***
The Crisis in Medicare: Proposals for Reform, Sioux City, Iowa, December 13, 1983.***

○